Patient Introduction

Date_____ Name_____ Age___ SS#_____ Pt.#_____

CURRENT Health Complaints (Symptoms) _____

_____

What Day Did Symptoms Start (Date) _____ Duration_____

How Did It Happen?_____

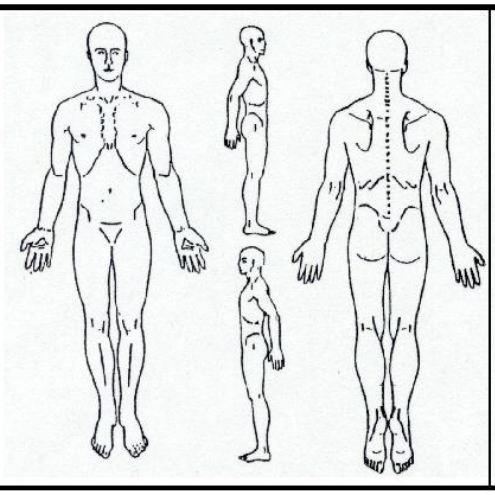
Are you claiming a ☐Auto Accident ☐Work Comp ☐3rd Party Liability (PI) Injury Date_____

What makes it better? ☐Nothing ☐Bending ☐Lifting ☐Sitting ☐Standing ☐Moving ☐Resting

What makes it worse? ☐Nothing ☐Bending ☐Lifting ☐Sitting ☐Standing ☐Moving ☐Resting

Please Mark The Problem Areas With The Following Letter:

A - Ache
P - Pain
N - Numbness
T - Tingling
B - Burning
S - Stabbing
R - Radiating



CHECK CURRENT AND PAST PROBLEMS

☐ Neck Complaints	☐ Wear Glasses	☐ Liver Trouble	☐ Menstrual Irregularity
☐ Headaches	☐ Light Bothers Eyes	☐ Gall Bladder Trouble	☐ Bladder Trouble
☐ Shooting Head Pain	☐ Grating In Neck	☐ Diabetes	☐ Allergies
☐ Sinus Trouble	☐ Tight Shoulders	☐ Low Back Complaints	☐ Asthma
☐ Loss of Smell	☐ Pins & Needles in	☐ Pinched Nerves in Back	☐ Fatigue
☐ Loss of Taste	☐ Arms and Hands	☐ Pins & Needles in legs	☐ Strokes
☐ Throat Inflammation	☐ Cold Hands	☐ Pain in Legs & Feet	☐ Low Blood Pressure
☐ Thyroid Trouble	☐ Mid Back Complaints	☐ Cold Feet	☐ High Blood Pressure
☐ Face Flushed	☐ Chest Pains	☐ Painful joints	☐ Anemia
☐ Twitching of Face	☐ Shortness of Breath	☐ Swollen Joints	☐ Rheumatic Fever
☐ Loss of Memory	☐ T.B. (Tuberculosis)	☐ Disc Problems	☐ Nerves/Nervousness
☐ Head Feels Heavy	☐ Heart Problems	☐ Intestinal Gas	☐ Inner Tension
☐ Dizziness	☐ Heart Attacks	☐ Constipation/Diarrhea	☐ Cold Sweats
☐ Fainting	☐ Stomach Troubles	☐ Kidney Trouble	☐ Cancer
☐ Loss of Balance	☐ Ulcers	☐ Sexual Dysfunction	☐ Sleeping Problems
☐ Ringing in Ears	☐ Indigestion	☐ Menstrual Cramps & Pain	☐ Arthritis

Women:
Are you pregnant? _____ If yes, (congratulations!) when are you due? _____
Are you nursing? _____