INITIAL PATIENT QUESTIONNAIRE

Name: _____ DOB: ___ /___ /___ Age: ___ SSN: ___-___-___ Sex: M☐F☐

Home Address: _____ City / State: _____ Zip:_____

Phone: (h) _____ (c) _____ Email:_____

Marital Status: _____ Occupation: _____ Employer:_____

Emergency Contact & Relation: _____ Phone:_____

I give permission for text messaging appointment reminders, communication and marketing: Yes ☐ No ☐

PATIENT INFORMATION CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What you're being asked to sign is simply a confirmation that you have been informed of the following:

EXAMINATIONS

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints; this is not a cause for alarm. There are some risks involved in doing these procedures. They are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.
Rib fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and, if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.
Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems[i]. Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable but estimates place risk of serious injury at about 1 serious complication per 100 million low back manipulations[ii].
Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people[iii]. Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke, secondary to chiropractic/adjustment/manipulation may occur in 1 per 100,000 patients[iv], a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen sodium, etc.) is 4 per 100,000 patients[v]. The risk of serious complication or death from spine surgeries of the neck is 1.25 per 1000 patients[vi]. As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemental procedures and tests that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ, OR HAVE HAD READ TO ME, THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANT TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient Signature: _____ Date: _____

Patient's Printed Name: _____ Date: _____

Parent's/Guardian's Signature: _____ Date: _____

(If patient is less than 18 years of age)

Parent's/Guardian's Printed Name: _____ Date: _____

[i] Troyanovich SJ, Harrison DE • Low back pain and the lumbar intervertebral disc. Clinical considerations for the Doctor of Chiropractic. [ii] Shekelle PG, Spine update. Spinal Manipulation, Spine 1994, 19, 858-86
[iii] Clayman CB, The American Medical Association Home Encyclopedia, New York, Random House: 947-948
[iv] Dabbs v. Lauretti WJ Risk Assessment and Cervical Manipulation vs. NSAIDS for the treatment of neck pain J Manipulative Physol. THE: 1995; 18•530536
[v] Harwitz PI, Acker PD, Adams AH, Meeker WP, Shekelle PG Manipulation and mobilization of the cervical spine; A systematic review of the literature. Spine, 1996, 21.1746-1760

HISTORY OF COLLISION

Date of Collision: _____/_____/_____ Time of Collision: ___: _____

Where were you seated? _____

Make / Model of the vehicle you were occupying: _____

Location where the collision occurred: _____

Approximately how fast were you traveling when the collision occurred? _____ MPH

Make / Model of the other vehicle(s) involved: _____

At the time of the collision, which way were you facing? Forward? Turned? _____

Were you surprised by the collision? ☐ Yes ☐ No Were you wearing a seat belt? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No Were you rendered unconscious? ☐ Yes ☐ No

Were the police notified? ☐ Yes ☐ No Was a report filed? ☐ Yes ☐ No

With whom? ☐ TPD ☐ HCSO ☐ Other:_____

How did you feel immediately following the collision? _____

_____

Is the pain… ☐ Getting better? ☐ No improvement? ☐ Getting worse?

Did you go to the hospital? ☐ Yes ☐ No

Were any of the following performed? ☐ X-rays ☐ CT ☐ MRI

Were you prescribed medication? ☐ Yes ☐ No If so, what was prescribed? _____

_____

Have you seen another doctor for this injury? ☐ Yes ☐ No If so, with whom? _____

Have you been able to work since the collision? ☐ Yes ☐ No Why or why not?_____

What could you do before the collision that you are unable to do now? _____

_____

Do you have an attorney? ☐ Yes ☐ No Who?_____

Patient Signature: _____ Date: _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF AUTO INSURANCE COMPANY	POLICY NUMBER	CLAIM NUMBER

NAME OF AUTO ADJUSTER	PHONE NUMBER FOR AUTO ADJUSTER

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NAME OF MEDICAL INSURANCE	INSURANCE MEMBER ID/SUBSCRIBER NUMBER

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ☐ OUT PATIENT ☐		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Gregory E. Cobb		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA “NO FAULT” AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____

SIGNATURE DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA “NO FAULT” AUTO INSURANCE LAW (CHAPTER 71-252 F.S.)

_____

SIGNATURE DATE

SOCIAL SECURITY NO.

ASSIGNMENT OF BENEFITS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION.

Cobb Rehab & Wellness

INSURANCE CARRIER: _____ CLAIM NUMBER: _____ DATE OF LOSS: _____

For an in consideration of Cobb Rehab & Wellness agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Cobb Rehab & wellness for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statue §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Cobb Rehab & Wellness to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Cobb Rehab & Wellness against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Cobb Rehab & Wellness as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Cobb Rehab & Wellness and their attorneys (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Cobb Rehab & Wellness including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Cobb Rehab & Wellness and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient.

I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Cobb Rehab & Wellness will bill & pursue collection against the insurance company and any other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Cobb Rehab & Wellness at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Cobb Rehab & Wellness at the address on the bill. Cobb Rehab & Wellness' medical care is being provided for a reasonable fee for treatment casually related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Cobb Rehab & Wellness. I further instruct my insurance company to make payment for charges submitted by Cobb Rehab & Wellness in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Cobb Rehab & Wellness limited power of attorney to endorse and sign my name on any draft for payment to either Cobb Rehab & Wellness or myself if said draft represents payment for charges related to services rendered by Cobb Rehab & Wellness.

I further direct my insurance carrier or responsible other entity to provide information to Cobb Rehab & Wellness which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the names of other medical providers to whom payments have been made under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Cobb Rehab & Wellness. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____ _____

Patient Signature Date Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

Cobb Rehab & Wellness
Dr. Gregory Cobb
4205 E. Busch Blvd. Tampa, FL 33617
Phone: (813) 914-8500 Fax: (813) 914-8511
www.cobbrehabwellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare

information for the above-named patient.

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☑ All healthcare information

☐ Other: _____

_____

To be completed by staff:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Signature: _____ Date Signed: _____

ADVANCED BENEFICIARY NOTICE

For patients treating as a result of an Automobile or Personal Injury

Please initial:

_____ I understand that Cobb Rehab & Wellness does not accept Commercial/Group Health Insurance's Fee Schedule for treatment of injuries involving an automobile accident.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that a copy of the Notice of Privacy Practices is posted and available at my request, and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print): _____ Date: _____

Parent, Guardian or Patient's Legal Representative: _____

Signature: _____

THIS FOR WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

How did you hear about our clinic?

☐ Location / Sign

☐ Insurance Provider

☐ Friend / Relative / Co-worker

☐ Dr. / clinic

(Name): _____

☐ Other (Name): Attorney _____

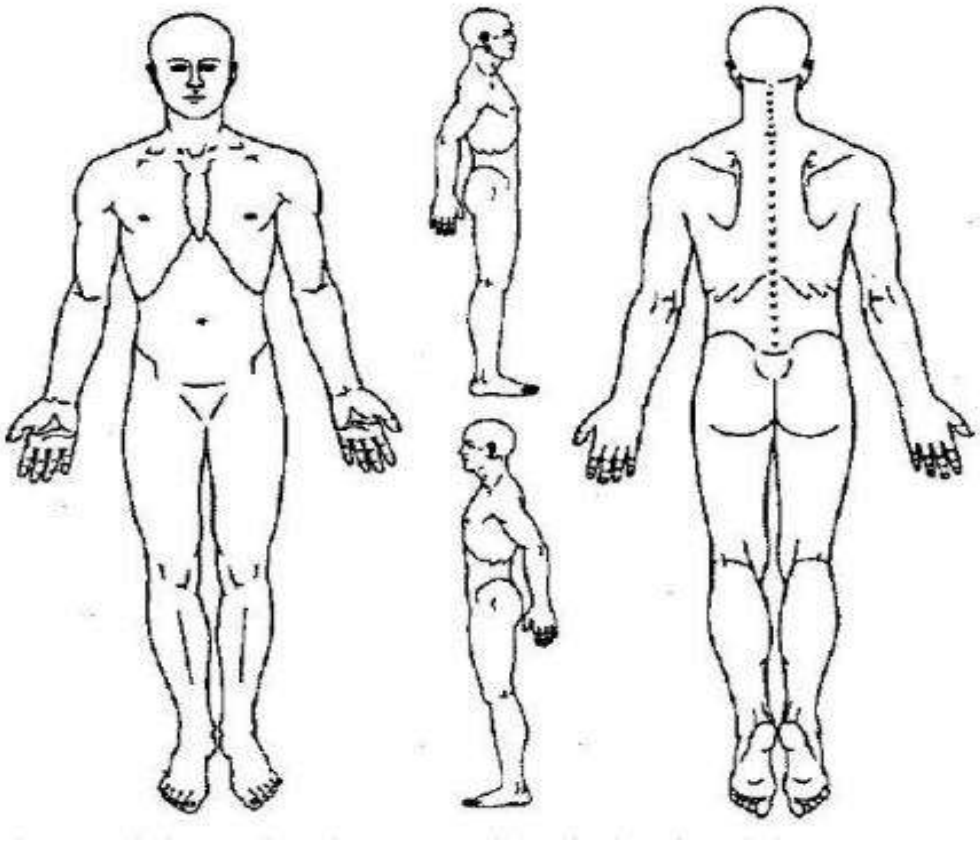
Thank you for choosing **Cobb Rehab & Wellness** for your healthcare needs!

Name: _____ Date:_____

Patient Condition

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), nark areas of radiating pain and include all affected areas. You may draw on the figure.

Numbness: ---- Pins and Needles: oooo Burning Pain: xxxx Stabbing Pain: //// Aching Pain: ((((



If there are any other specifics list them here

Rate the severity of your pain on a scale from 1 (LEAST PAIN) to 10 (UNBEARABLE PAIN):

Right Now: 1☐ 2 ☐ 3☐4 ☐ 5 ☐ 6☐ 7☐ 8☐ 9 ☐ 10 ☐

Average Pain: 1☐ 2 ☐ 3☐4 ☐ 5☐ 6☐ 7 ☐8☐ 9☐ 10☐

At Best: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9 ☐ 10☐

At Worst: 1☐ 2 ☐ 3☐ 4☐ 5 ☐6☐ 7 ☐ 8☐ 9 ☐ 10 ☐

Name: _____ Date: _____

PATIENT INTAKE

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. How often do you experience your symptoms?

   Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently ☐

   (76-100% of the time) (51-75% of the time) (26-50% of the time) (1-25% of the time)
3. How would you describe the type of pain?

   ☐ Numb ☐ Achy ☐ Sharp ☐ Sharp with motion ☐ Stabbing with motion

   ☐ Dull ☐ Burning ☐ Shooting ☐ Shooting with motion ☐ Electric with motion

   ☐ Tingly ☐ Stiff ☐ Diffuse ☐ Other: _____
4. How are your symptoms changing with time? ☐ Getting worse ☐ Staying the same ☐ Getting better
5. Using a scale from 0-10 (10 being the worse), how would you rate your problem?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. How much has the problem interfered with your work?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
7. How much has the problem interfered with your social activities?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. Who else have you seen for your problem?

   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician

   ☐ Massage Therapist ☐ Physical Therapist ☐ ER Physician

   ☐ Orthopedist ☐ No one ☐ Other _____
9. How long has this episode been happening? _____
10. How do you think your problem began? _____
11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No
12. What aggravates your problem? _____

    _____
13. What makes it better? _____
14. What concerns you the most about your problem; what does it prevent you from doing?

    _____

15. What is your: Height: _____ Weight: _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ ALS ☐ Lupus ☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ Rheumatoid Arthritis

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have the condition, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Asthma	☐	☐	Muscular Incoordination
☐	☐	Neck Pain	☐	☐	Chronic Sinusitis	☐	☐	Liver/Gallbladder Disorder
☐	☐	Upper Back Pain	☐	☐	High Blood Pressure	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Mid Back Pain	☐	☐	Heart Attack	☐	☐	Loss of Appetite
☐	☐	Low Back Pain	☐	☐	Chest Pains	☐	☐	Diabetes
☐	☐	Shoulder Pain	☐	☐	Stroke	☐	☐	Excessive Thirst
☐	☐	Elbow/Arm Pain	☐	☐	Angina	☐	☐	Frequent Urination
☐	☐	Wrist Pain	☐	☐	Kidney Stones	☐	☐	Smoking/Tobacco Use
☐	☐	Hand Pain	☐	☐	Kidney Disorders	☐	☐	Drug/Alcohol Dependence
☐	☐	Hip Pain	☐	☐	Bladder Infection	☐	☐	Allergies
☐	☐	Upper Leg Pain	☐	☐	Painful Urination	☐	☐	Depression
☐	☐	Knee Pain	☐	☐	Loss of Bladder Control	☐	☐	Systemic Lupus
☐	☐	Ankle/Foot Pain	☐	☐	Prostate Problems	☐	☐	Epilepsy
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Dizziness			**For Females Only**
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Birth Control Pills
☐	☐	Tumor	☐	☐	Visual Disturbances	☐	☐	Hormonal Replacement
☐	☐	Other: _____				☐	☐	Pregnancy

20. List all prescription medications you are currently taking: _____

_____

21. List all of the over-the-counter medications you are currently taking: _____

_____

22. List all the supplements you are taking: _____

_____

23. List all the surgical procedures you have had: _____

_____

24. What is your occupation? _____

25. What activities do you do at work

Sit: ☐ Most of the day ☐ Half of the day ☐ A little of the day

Stand: ☐ Most of the day ☐ Half of the day ☐ A little of the day

Computer Work: ☐ Most of the day ☐ Half of the day ☐ A little of the day

On The Phone: ☐ Most of the day ☐ Half of the day ☐ A little of the day

26. What activities do you do outside of work? _____

27. Have you ever been hospitalized? If yes, why? _____

_____

28. Have you had significant trauma? If yes, why? _____

_____

29. Anything else pertinent to your visit today? _____

_____

Patient Signature: _____ Date: _____