



PATIENT INFORMATION FORM

Name _____ Date _____

Street Address _____

Town, State, Zip Code _____

Phone (H) _____ (W) _____ (C) _____

Social Security Number _____ Date of Birth _____

Sex: () Male () Female Status: () Single () Married () Widowed () Other

Email _____ How did you find us? _____

Emergency Name and Phone _____

Occupation _____ Employer _____

Employer Address _____

Medical Information

Have you been diagnosed as having any of the following conditions?

	NO	YES		NO	YES
Cancer	()	()	Diabetes	()	()
Chest Pain	()	()	Asthma	()	()
High Blood Pressure	()	()	Pulmonary Problems	()	()
Heart Disease	()	()	Ulcers	()	()
Heart Attack	()	()	Headaches	()	()
Heart Palpitations	()	()	Kidney Problems	()	()
Pacemaker	()	()	Are you pregnant?	()	()
Bleeding Problems	()	()	Osteoporosis/Osteopenia	()	()
Smoking	()	()	Bowel/Bladder Problems	()	()
Stroke/CVA	()	()	Liver/Gallbladder Problems	()	()
Allergies	()	()	Special Diet Guidelines	()	()
Seizures	()	()	Metal Implants	()	()
Dizziness/Fainting	()	()	Recent Fractures	()	()
Skin Abnormalities	()	()	Sexual Dysfunction	()	()
Nausea/Vomiting	()	()	Ringling in your ears	()	()
Hypoglycemia	()	()	Rheumatoid Arthritis	()	()
Falls	()	()	TMJ	()	()
Hernia	()	()	Other _____		

If yes on any of the above, please briefly explain and give approximated dates:

Patient Signature _____



Name _____ Date _____ Date of Birth _____

Surgical History: Please list procedure and date.

1. _____
2. _____
3. _____
4. _____
5. _____

Medications: Please include prescription *and* over the counter medications, supplements and amounts in milligrams.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Pain Scale: Mark roughly where your pain is on the scale.

0 (none) |-----| 10 (worst)

Do symptoms wake you up at night? Yes / No

Symptoms increase with _____

Symptoms decrease with _____

Prior Level of Function _____

Have you fallen in the last year? ()yes () no. How many times? _____

Have you been injured in any fall in the last year? () yes () no.

Functional Activities that Aggravate Symptoms:

Sitting _____

Looking over shoulder _____

Lifting/carrying _____

Desk/work environment _____

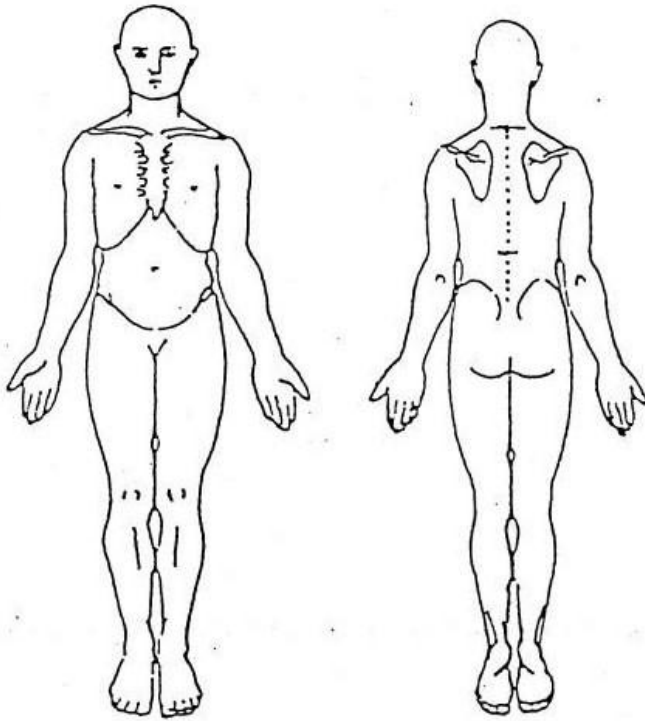
Sleeping _____

Other _____

Patient Signature _____



Pain Diagram: Please mark the location of your symptoms using the following diagram and symbol key.



Key

///: Pins and Needles

X: Pain

0: Numbness

Pain Questionnaire: Here are many words that describe pain. Check () any word that describes the pain you are currently experiencing.

- | | | | | | | |
|---------------|--------------|---------------|------------|---------------|-------------|---------------|
| 1. Flickering | 2. Jumping | 3. Prickling | 4. Sharp | 5. Pinching | 6. Tugging | 7. Hot |
| Quivering | Flashing | Boring | Cutting | Pressing | Pulling | Burning |
| Pulsing | Shooting | Drilling | Lacerating | Gnawing | Wrenching | Scalding |
| Throbbing | Stabbing | | | Cramping | | Searing |
| Beating | | | | Crushing | | |
| Pounding | | | | | | |
| 8. Tingling | 9. Dull | 10. Tender | 11. Tiring | 12. Sickening | 13. Fearful | 14. Punishing |
| Itchy | Sore | Taught | Exhausting | Suffocating | Frightening | Grueling |
| Smarting | Aching | Rasping | | | Terrifying | Cruel |
| Stinging | Heavy | Splitting | | | | Vicious |
| | Hurting | | | | | Killing |
| 15. Wretched | 16. Annoying | 17. Spreading | 18. Tight | 19. Cool | 20. Nagging | |
| Blinding | Troublesome | Radiating | Numb | Cold | Nauseating | |
| | Miserable | Penetrating | Drawing | Freezing | Agonizing | |
| | Intense | Piercing | Squeezing | | Dreadful | |
| | Unbearable | | Tearing | | Torturing | |

Patient Signature _____