PATIENT HISTORY

Date of Birth_____ Social Security Number _____-_____-_____
Last Name _____ First Name _____MI_____
Address _____ Apt # _____
City _____ ST_____ Zip _____
Phone (H) _____(W) _____ (Cell) _____
Spouse's Name _____ Spouse's Birthday _____
Your Occupation _____ Employer _____
Employer Address _____
Insurance Company _____ Policy Number _____
Have you ever been to another doctor for this problem? Y N Who? _____
Who referred you to this office? _____
E-Mail Address_____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain Unbearable Pain

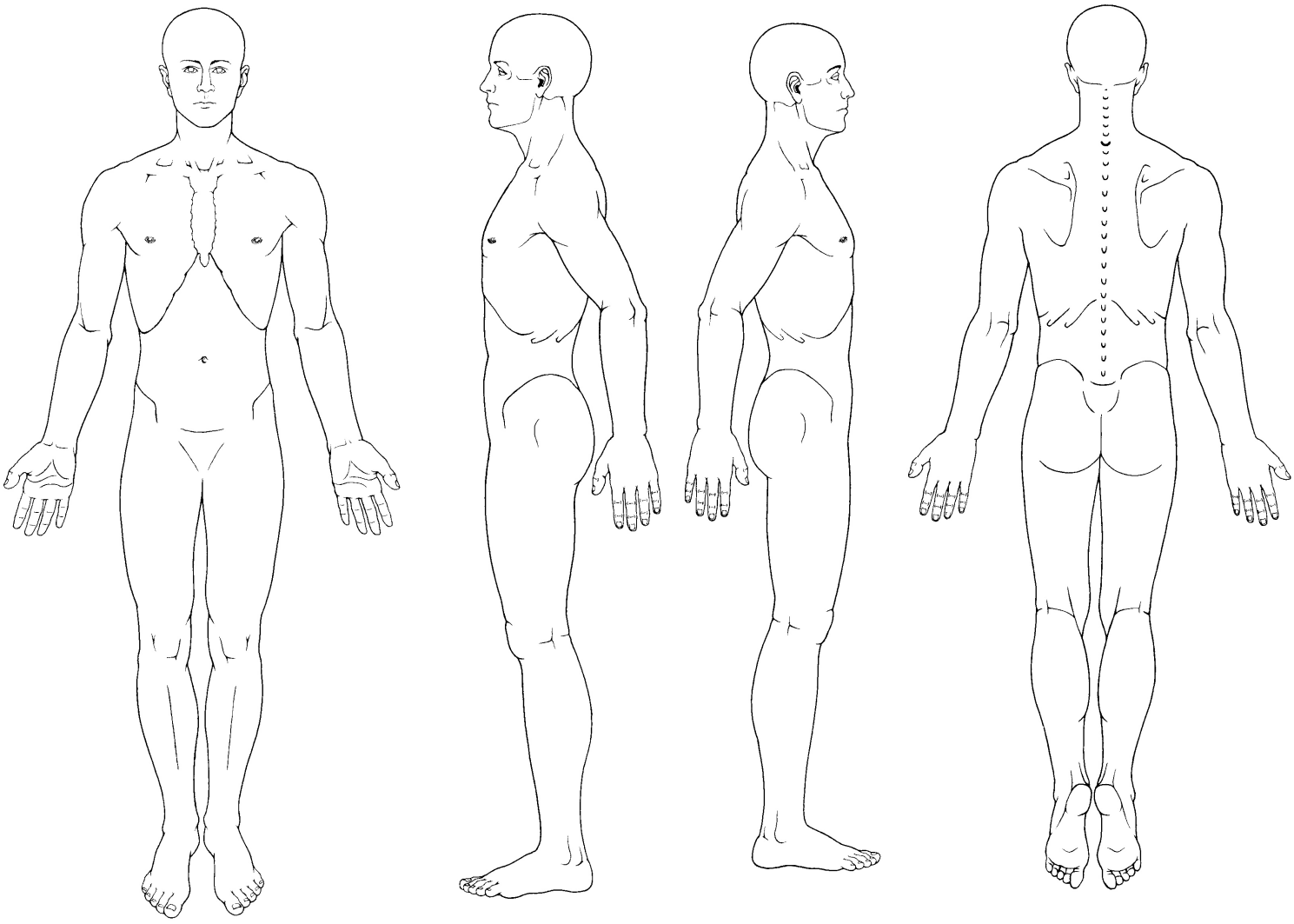
OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain Unbearable Pain

PATIENT SIGNATURE _____DATE _____

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE _____DATE _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____
Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Dates of Treatment _____
Type of Treatment or Drugs Prescribed _____

Please list all past surgeries:

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

_____
_____
_____

Please do not write below this line

DOCTORS NOTES :

_____
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PATIENT SIGNATURE _____DATE _____