Patient Name _____ Birthdate _____ Sex M / F

Address _____ City _____

State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____

Occupation _____ Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

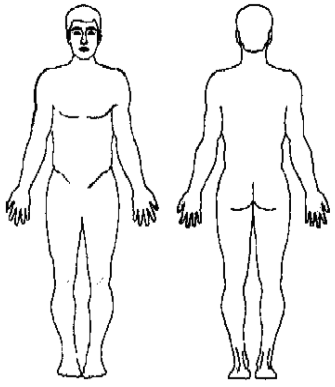
Subscriber Name _____ Health Plan: _____

Subscriber ID # _____ Group # _____ Spouse Name _____

Spouse Employer _____ City _____ State _____ Zip _____

Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

☐ Other _____

**Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

**Date Problem Began:** _____

**How Problem Began:** _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?** ☐ No ☐ Yes

**Date(s) taken:** _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
_____
☐ Medications _____
_____
_____

**Family History:** ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

**Patient Signature** _____ **Date** _____