



Date \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
 Cellular Phone Number \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Sex M ( ) F ( )  
 Referred By \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Do you prefer to receive calls at: Home ( ) Work ( ) Cell ( )  
 List previous surgeries and dates: \_\_\_\_\_

List major illnesses and dates: \_\_\_\_\_

**Patient's Symptoms:**

Describe area(s) of complaint: \_\_\_\_\_

How long have you been experiencing symptoms? \_\_\_\_\_

What treatments, if any, did you receive in the past? \_\_\_\_\_

Is this condition getting better, worse or staying the same? \_\_\_\_\_

What aggravates your symptoms? \_\_\_\_\_

How does your current condition interfere with your ability to do/perform activities?) \_\_\_\_\_

Date of last X-Ray \_\_\_\_\_

Date of last MRI \_\_\_\_\_

Do you have any metal hardware from spinal/hip/brain surgeries No ( ) Yes ( ) Where? \_\_\_\_\_

Any accidents, falls, etc, that may have caused your problem? \_\_\_\_\_

Drugs you take now: ( ) Pain killers ( ) Muscle relaxers ( ) other (list) \_\_\_\_\_

Activities you participate in: Tennis \_\_\_\_\_ Golf \_\_\_\_\_ Jogging \_\_\_\_\_ Weight Lifting \_\_\_\_\_

Gardening \_\_\_\_\_ Exercise \_\_\_\_\_ Any other strenuous physical activities \_\_\_\_\_

**Women: Are you pregnant? YES NO**

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_