

CURRENT MEDICAL PROBLEM

Name of Patient _____ Age _____ Sex _____ Birth date _____ Today's Date _____

Consulting Doctor (Name of doctor who sent you here): _____

Primary Care Doctor: _____

Dominant Hand
R L

Please tell us why you are here today: _____

Where is your pain (problem): _____

Was there an accident or injury: _____

Does this condition affect your Right Side Left Side Is this work related? No Yes

When did this start: _____

What is the pain like: _____

Is the pain constant or intermittent ?

What makes it worse: _____

What makes it better: _____

Is it getting: Better Worse

What other symptoms do you have: _____

Have you had any treatment for this to this date: No Yes By whom: _____

If so, please indicate treatment by marking the appropriate box:

Therapy Injections Surgery Hospitalization Chiropractic Acupuncture Brace

How has this been evaluated:

X-rays Cat Scan MRI EMG's Bone Scan Discogram

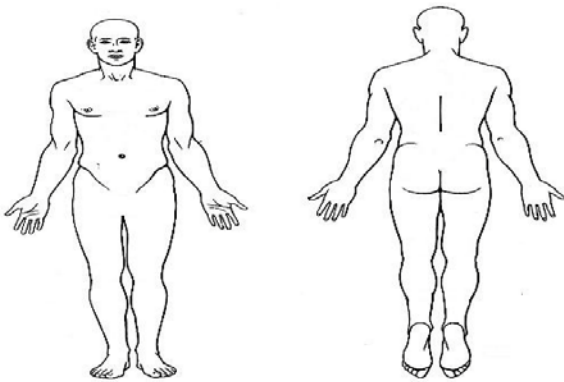
Have you tried any medication for this problem? No Yes Please list: _____

Diagram

(mark parts of your body where you feel the problem. Use the appropriate symbols indicated below)

Ache X Stabbing ////
Swelling □ Numbness ○
Pins/Needles ••• Popping, Cracking, Grinding △

Your Approx. Height _____



Right Left Left Right
Front Back

Severity of pain: 10 being worst
---/---/---/---/---/---/---/---/---/---
1 2 3 4 5 6 7 8 9 10

For office use only:			
Date _____	WT _____		
P _____	T _____	IN _____	

I certify to the best of my knowledge that the above information is correct

Patient/Gaurdian Signature _____ Date: _____

I have reviewed and agree with the findings as noted Physicians Signature: _____