

Facility: _____

Patient Name _____ Subscriber ID # _____ Primary Language _____

DOB: _____

Describe Your Current Problem and How It Began _____

Onset date/Surgery date _____

Is this? Work Related Auto Related N/A

How often are your symptoms present?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

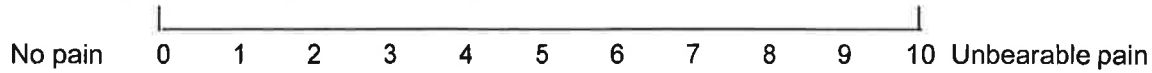
Describe the nature of your pain:

- Sharp Dull Ache Numb Shooting Burning Tingling

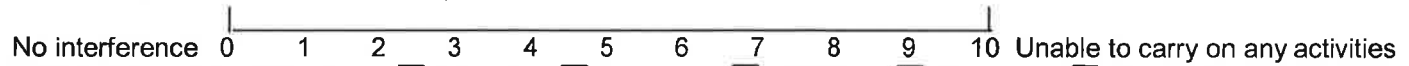
How is your condition changing?

- Getting Better Not Changing Getting Worse

Current complaint (how you feel today):



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



Check if you have difficulty: Seeing Hearing Talking Memory Swallowing

What is your most effective learning method: Seeing Hearing Talking Doing Pictures

In general would you say your overall health right now is:

- Excellent Very Good Good Fair Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? Yes No

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

Please check all of the following that apply to you:

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Cardiac Condition
- Stroke (Date) _____
- Dizziness/Fainting
- Cancer/Tumor (Explain) _____
- Osteoporosis
- Other Health Problems (Explain) _____
- Numbness /Weakness (Location) _____
- Urinary Problems
- Currently Pregnant, # Weeks _____
- Abnormal Weight Gain Loss
- Pain Unrelieved by Position or Rest
- Pain at Night
- Surgeries _____
- Tobacco Use - Type _____
Frequency _____ /Day
- Current Medications see page 2 _____

more space see page 2

Who have you seen for your condition before today? NoOne

- Medical Doctor Massage Therapist Chiropractor Other _____
- Physical Therapist Acupuncturist Occupational Therapist Speech Therapist Athletic Trainer

What treatment did you receive and when? _____

What is your occupation? _____

Medical History Page 2

Last name: _____ First Name: _____ D.O.B. _____

Allergies: Are you latex sensitive? yes no List any other allergies: _____

Do you have a pace maker or medical implant? yes no

SURGERIES (cont from page 1):

Include Date Reason for Surgeries:

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

MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc). You may attach a copy of your own list of medications if available.

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

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Dosage: _____ Frequency: _____
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Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature _____ **Date** _____

Reviewed with Patient: _____ **Date:** _____