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Name: _____ **Date of Birth:** ____/___/____ **Age:** _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑F ❑M **Height:** _____ **Weight:**_____ **Race:**_____ **Ethnicity:**_____ **Primary Language:** _____

Patient's Marital Status_____ **Nearest Relative**_____

Patient's Address_____ **City**_____ **Zip**_____

Name of Responsible Party if Patient is a Minor_____

Insurance_____ **Main subscriber on the insurance**_____ **DOB**_____

Patient SS#_____ **Home Phone** ( )_____ **Cell**( )_____

Email_____ **Patient's Employer** (If minor, Responsible Party) _____

Occupation_____ **Work Address**_____ **Work Tel** ( ) _____

Spouse's Employer_____ **Spouse's Name**_____ **Work Tel** ( ) _____

Referred here by (check one) ❑Self ❑Family ❑Friend ❑Doctor ❑Other Health Professional

Name of person making referral:_____

Primary Care Physician/Internist: _____ Cardiologist: _____

(Would you like records sent to any of these Doctors? (Yes/No) **Please Circle One**

Have you had a recent medical evaluation by one of these doctors? _____ Name of Doctor: _____

What is your primary problem for being seen today?

Where is your Pain? **Body Part:** _____ **Right or Left (circle one)**

Length of Symptoms:_____ **Date of Injury**:_____

Describe your injury and symptoms: _____

_____

Does your pain **Radiate** up or down? YES NO (If yes: up down both)

Do you have any weakness? YES NO

Do you have **Numbness and/or tingling** YES NO

Have you had **Surgery** on this body part? YES NO

If yes, describe the procedure: _____

Date(s) / Surgeon(s): _____

Have you had **Physical Therapy**? YES NO If yes, how many visits ____

Have you had any **Images** taken on this body part? MRI CT EMG Bone Scan Xray (circle all that apply)

Findings:_____

Have you had an **Injection**(s)? YES NO If yes, how many _____

What **Pain Medicine** are you taking for this problem? _____

Past Medical History:

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _____

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

_____

Drug Allergies: Yes No **List allergies?** _____

Type of Reaction:_____