First Name: ______________ Last: __________________________ Social Security No.: ______________

Address: ______________________________________ City: __________________ ZIP: __________

Email Address: ____

Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Other: ______________ Birth Date: ____________ Age: _____

Phone (Please check first number to call) ☐ Home: ________ ☐ Cell: ___________ ☐ Work: ___________

Occupation: _______________________ Employer: ____________________________________

Name of Significant Other : ____________________________________ Occupation: ____________

Employer: ______________________________ Office Phone: ______________ Number of Children: _____

Referred to us by: ________________________________ Date of last Physical Examination: ________

Purpose of today's Appt: ☐ Headache ☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Other________

How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Frequently (50-75%) □ Occasionally (26-50%) □ Intermittently (0-25%)

How would you describe the type of pain?
□ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion □ Achy □ Shooting with motion
□ Burning □ Stabbing with motion □ Shooting □ Electric like with motion □ Stiff □ Other: ______________

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Physical Therapist □ Massage Therapist □ No one □ Other ____________

How long have you had this problem? __________ day(s) week(s) month(s) year(s) (*Please circle*)

How do you think your problem began? ____

What concerns you the most about your problem; what does it prevent you from doing?

____

List all prescription and over the counter medications you are currently taking:

____

List all surgical procedures and Hospitalizations you have had:

____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of Person Responsible for Payment: __________________________ Relationship to Patient: ____________

Patient's Signature: ____ Date: ______________

Parent or Guardian Signature: ____ Date: ______________

 Form continues on reverse side for Accidental Injuries and Additional Insurance Information