Patient Name: ___________________________________Acct#___________ Date:__________

TODAY'S CHIEF COMPLAINT: ____

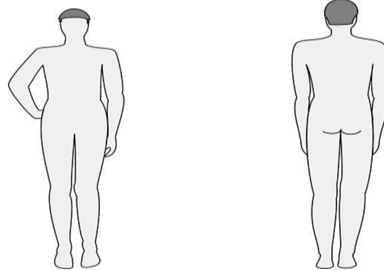
Have you seen another Doctor for this condition? ____ Name of Doctor: ______________________
Have you had any X-rays, MRIs, CTs or Ultrasounds for this condition? ______________________
Where? ____
Name of your Primary Care Doctor :____

Is this condition due to: Auto Accident ____ Work Related ____ Fall ____ Other______________
Date of Accident: ______ Were you treated at the ER? ____ Name of Facility: _______________
Were MRIs, CTs, Ultrasounds or X-rays done? ____ Where?
____

ACTIVITIES OF DAILY LIVING: (Circle affected areas)

Eating Bathing Toileting Transferring Dressing Grooming Sleeping Thinking Sitting
Walking Stairs Reaching Lifting Bending Stooping Kneeling Squatting Grasping
Weakness Where?

Mark the area on the body where you feel the described sensations.
Pins and Needles xxxx Burning ==== Stabbing////// Numbness*****



Medications ? ____

List Allergies: ____

Past Medical History:
Have you had any of the following problems (circle all that apply)
Asthma Bowel disorder Cancer Depression Diabetes Bladder disorder
Heart disease Kidney disease Lung disease Bronchitis Tuberculosis Stroke Polio
High Blood pressure Rheumatism Seizure Mental Illness Thyroid Ulcer Other: ___________

Past Surgical History: ____

Family History: Do you have a family history with any of the following **(circle all that apply)**
Diabetes Rheumatoid arthritis Back problems Cancer Tuberculosis
Heart Attacks Hypertension Other: ____

Social History: Smoker? Y / N ____Packs per day Alcohol use? Y / N #____drinks per week

Work History: Describe your job duties: ____

Name of Employer:____