

Patient Name: _____ Birthdate: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

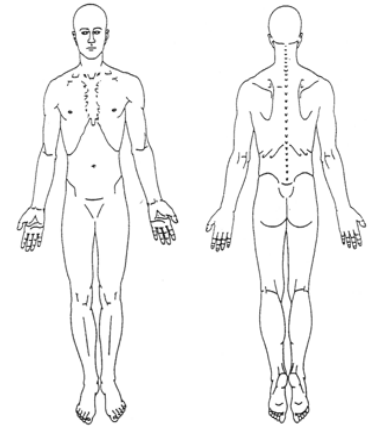
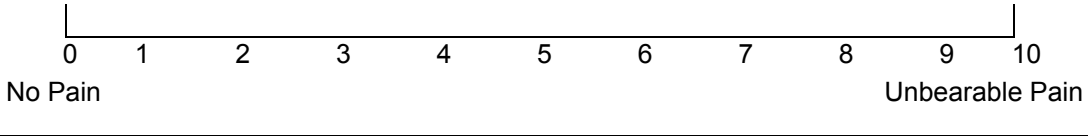
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN:

Current complaint (how you feel today):



How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100%

Can you perform your daily activities? Yes No (Describe)

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date (s) taken: _____

WHAT AREAS WERE TAKEN?

Please check all of the following that apply to you: None Apply

No	Yes	Condition	No	Yes	Condition
<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # of births _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	History of Low/Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____	<input type="checkbox"/>	<input type="checkbox"/>	History of Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries/Medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor			_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Trauma			_____

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____

Date: _____