Name ______________________________ Date ______________________

Height __________ Weight __________ Occupation ______________________

Referring Physician ______________________________

1. Please describe in detail the condition we are seeing you for:

____

____

____

2. Date of onset: ______________

3. Do you have (circle all that apply): pain numbness tingling weakness

4. Are your symptoms (circle one): continuous intermittent

5. Are your symptoms (circle one): getting better staying the same getting worse

6. Please mark on the line to indicate how severe your pain was:

at its worst (write "W") and as it is today (write "T")

NO PAIN [0 --------------------------------5-------------------------------- 10] PAIN AS BAD AS IT CAN GET

7. Do symptoms awaken you at night? (circle one) yes no

8. What time of day is it worse? ______________________________

9. What makes your symptoms worse? ______________________________

10. What makes your symptoms better? ______________________________

11. What previous tests/treatments have you received for the condition?
(MRI, x-ray, physical therapy, chiropractic)

____

12. Please indicate any of the following you have seen in the past months and describe the reasons:

Medical/Doctor: ______________________________

Osteopath: ______________________________

Physical Therapist: ______________________________

13. Please list any other diagnosed medical problems: Heart Disease, cancer, Diabetes, hepatitis, etc)

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____

14. Have you experienced any of the following? (circle all that apply)

Weakness Weight gain Weight loss Numbness Tingling Fatigue Fever/sweats

15. Please list all previous injuries and surgeries with approximate dates:

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____

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16. List all medications you have taken recently (prescription and non-prescription):

____

____

____

17. When is your next doctor's appointment? ___________________________________

18. How is your general health? (circle one) Excellent Good Fair Poor

19. Are you currently exercising? (circle one) Yes No