PATIENT HISTORY

Name:	Home Phone	Cell Phone	Work Phone	Age:
Occupation:		Referring Physician:		

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Kidney Problems			Thyroid Problems		
Arthritis			Presently Pregnant			CVA/Stroke		
High Blood Pressure			Allergies			Previous Fracture		
Heart Disease			Seizures			Osteoporosis		
Pacemaker or surgical implant			Metal in Body			Respiratory		
Headaches			Cancer/Tumor			Other		

PLEASE TELL US MORE ABOUT YOUR ACCIDENT AND/OR SYMPTOMS

Start Date	Where did it start? O Home O Car Accident O Work O Other	What were you doing?

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you had surgery in the past 6 months	YES	NO
Have you had physical therapy in the past for this condition?	YES	NO
In the past month, have you felt down, depressed or hopeless?	YES	NO
In the past month, have you had little interest in doing things?	YES	NO
Are you currently off work or on restricted daily duty due to this condition?	YES	NO
Do you smoke, use tobacco products or artificial sweeteners?	YES	NO

What type?

PLEASE LIST YOU ALLERGIES BELOW

Medication:

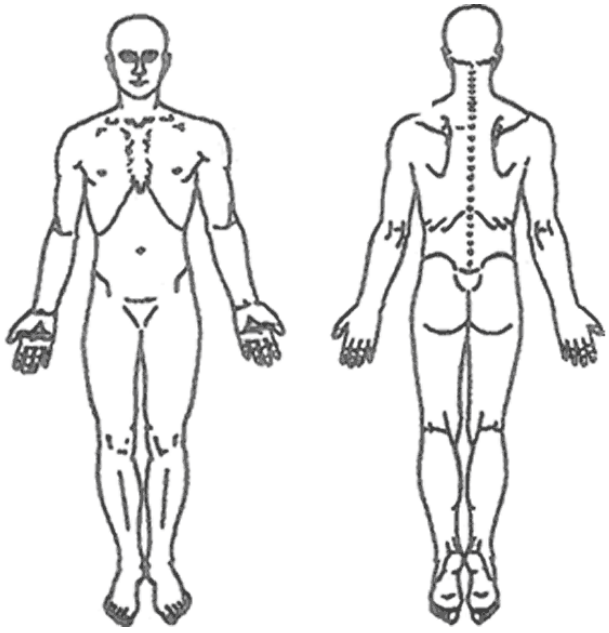
Food:

Skin:

Please list your PRESCRIPTION Medications

Please list your Over-The-Counter Medications

Please mark on the drawing where your pain is located



Where is most of the pain located?

- O Back
- O Neck
- O Shoulder
- O Elbow
- O Wrist
- O Hand
- O Hip
- O Knee
- O Ankle
- O Foot

Patient/Guardian Signature: Date: