



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

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

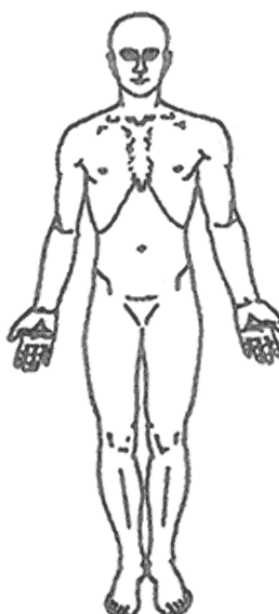
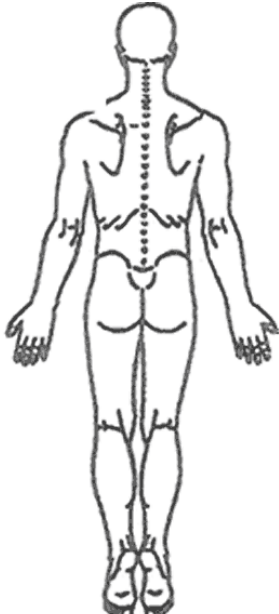
Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Kidney Problems			Thyroid Problems		
Arthritis			Presently Pregnant			CVA/Stroke		
High Blood Pressure			Allergies			Previous Fracture		
Heart Disease			Seizures			Osteoporosis		
Pacemaker or surgical implant			Metal in Body			Respiratory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

PLEASE TELL US MORE ABOUT YOUR ACCIDENT AND/OR SYMPTOMS

Start Date	Where did it start?	<input type="radio"/> Home	<input type="radio"/> Car Accident	What were you doing?
		<input type="radio"/> Work	<input type="radio"/> Other	
PLEASE ANSWER THE FOLLOWING QUESTIONS			YES	NO
Have you had physical therapy in the past for this condition?				
Have you had surgery in the past 6 months?				
In the past month, have you felt down, depressed or hopeless?				
In the past month, have you had little interest in doing things?				
Are you currently off work or on restricted daily duty due to this condition?				
Are you currently receiving home health services like nursing, PT, OT, etc.?				
Do you smoke, use tobacco products or artificial sweeteners?				
			Office Use Only	
			BP:	Right / Left
			HR:	
			Temp:	O2 Sat:

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?

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

Patient/Guardian Signature:	Date:
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