



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)

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:

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

