NAME: _____ **DATE:** _____

LAST FOUR DIGITS OF SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ DO YOU HAVE ANY FORMS TO BE FILLED OUT TODAY?_____

PLEASE USE THE SYMBOLS TO DESCRIBE YOUR SYMPTOMS. MARK THE LOCATION ON THE BODY DRAWING BELOW.

ACHING ʌʌʌʌ

STABBING /////

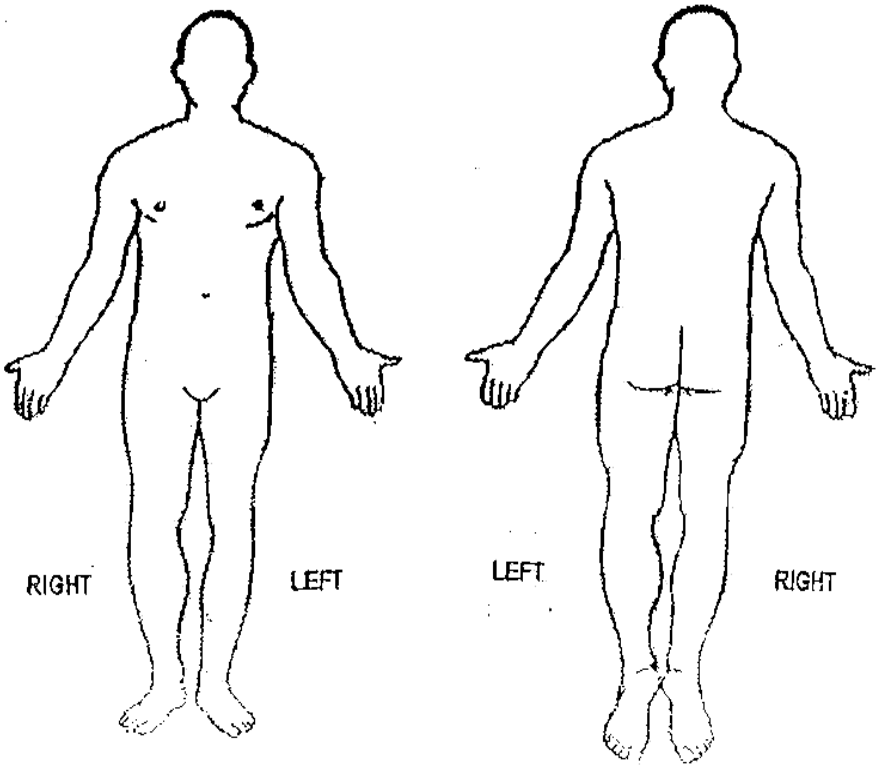
TINGLING ═══

BURNING XXXX

NUMBNESS oooo

SPASM ssssssss

WEAKNESS □□□□



BP **PULSE**

HOW BAD IS YOUR PAIN NOW? PLEASE INDICATE PAIN LEVEL FROM 1 TO 10

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST PAIN**

REASON FOR TODAY'S VISIT:_____

ANY NEW STUDIES? (MRI, CT SCAN, EMG, DISCOGRAM, LABS, ETC.)_____

ANY NEW CONSULTATIONS OR SURGERIES?_____

ANY NEW MEDICAL CONDITIONS?: _____

PLEASE LIST ALL CURRENT MEDICATIONS: (PLEASE CHECK √ BOX FOR MEDICATIONS NEEDING RENEWAL).

☐ _____ ☐ _____ ☐ _____

☐_____ ☐ _____ ☐ _____

DO YOU RECEIVE PAIN MEDICATION PRESCRIPTIONS FROM ANY OTHER PHYSICIAN? YES ☐ NO ☐

DO YOU TAKE ASPIRIN **YES ☐ NO ☐** DO YOU TAKE FISH OIL **YES ☐ NO ☐** DO YOU TAKE VITAMIN E **YES ☐ NO ☐**

UNDER WHAT INSURANCE/CASE ARE YOU BEING SEEN TODAY?_____

IF YOUR CONDITION IS WORK RELATED OR DUE TO A MOTOR VEHICLE ACCIDENT, PLEASE GIVE ACCIDENT DATE: _____

ARE YOU OUT OF WORK DUE TO THIS CONDITION? **YES ☐** **NO ☐** If yes, please give date you last worked: _____

Work: F/T ____ P/T ____ Light duty _____ Retired ____ Disabled: _____ Unemployed: _____

PATIENT'S SIGNATURE: _____ **PROVIDER INITIALS:** _____