Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	Nickname:	Date of Birth:	Sex: qM qF

Street address:	Work Phone:	Home Phone:	Preferred Phone: qHome qWork qCell

Address Line 2:	Cell Phone:	Cell Service Provider:

City:	State:	Zip Code:	Email:

Would you like to receive appointment reminders? Choose ONE:
qEmail qText Message qPhone Call qNone

Preferred Language: qEnglish qSpanish qGerman qFrench qItalian qRussian qPortuguese qChinese qJapanese qKorean qVietnamese qDecline to Answer qOther __________________

Please check ALL races that apply: qWhite qBlack or African American qAmerican Indian or Alaska Native qAsian qNative Hawaiian/Pacific Islander qDecline to Answer

Ethnicity:qHispanic or Latino qNon-Hispanic nor Latino qDeclined to Answer

Preferred Communication: qCell Phone qHome Phone qWork Phone qMail qEmail qIn Person

Smoking Status: qCurrent everyday qCurrent some days qFormer qNever Start Year _____ Quit Date _______

Current Medications:
1.Drug Name: ____________________________ Strength (eg. 10MG) ________Dose (e.g. 1 tab)__________ Frequency (e.g. once daily) _________________Date Started: ______________
2. Drug Name: ____________________________ Strength (eg. 10MG) ________Dose (e.g. 1 tab)__________ Frequency (e.g. once daily) _________________Date Started: ______________
3. Drug Name: ____________________________ Strength (eg. 10MG) ________Dose (e.g. 1 tab)__________ Frequency (e.g. once daily) _________________Date Started: ______________
4. Drug Name: ____________________________ Strength (eg. 10MG) ________Dose (e.g. 1 tab)__________ Frequency (e.g. once daily) _________________Date Started: ______________
5. Drug Name: ____________________________ Strength (eg. 10MG) ________Dose (e.g. 1 tab)__________ Frequency (e.g. once daily) _________________Date Started: ______________

Drug Allergies:
1. Drug Name ________________________ Reaction (e.g. hives) ________________ Date Started: __________
2. Drug Name ________________________ Reaction (e.g. hives) ________________ Date Started: __________
3. Drug Name ________________________ Reaction (e.g. hives) ________________ Date Started: __________

Referred by:	Referring Physician?:

Alcohol Use: qNone qLight qModerate qHeavy	Drug Use: qNone qLight qModerate qHeavy	Exercise: qNone qLight qModerate qHeavy

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient is the qSpouse qChild qSelf q________________ to the insured.	Ins. Date of Birth:
Insured Address (if different from patient):	

Address 2:	City:	State:	Zip Code:

Deductible?	Coinsurance/Copay?
Secondary Insurance:	Insured ID:

FAMILY HISTORY							
Please indicate which conditions exist or have existed by marking the boxes below.							
	Self	Mother	Fathe r	Siste r	Brothe r	Son	Daughte r
Bone Cancer	q	q	q	q	q	q	q
Brain Cancer	q	q	q	q	q	q	q
Breast Cancer	q	q	q	q	q	q	q
Colon Cancer	q	q	q	q	q	q	q
Esophageal Cancer	q	q	q	q	q	q	q
Gastric Cancer	q	q	q	q	q	q	q
Kidney Cancer	q	q	q	q	q	q	q
Leukemia	q	q	q	q	q	q	q
Liver Cancer	q	q	q	q	q	q	q
Muscle Cancer	q	q	q	q	q	q	q
Other Cancer	q	q	q	q	q	q	q
Ovarian Cancer	q	q	q	q	q	q	q
Pancreatic Cancer	q	q	q	q	q	q	q
Prostate Cancer	q	q	q	q	q	q	q
Rectal Cancer	q	q	q	q	q	q	q
Skin Cancer	q	q	q	q	q	q	q
Thyroid Cancer	q	q	q	q	q	q	q
Clotting Disorder	q	q	q	q	q	q	q
Deep Vein Thrombosis	q	q	q	q	q	q	q
Pulmonary Embolism	q	q	q	q	q	q	q
Unknown Clotting Disorder	q	q	q	q	q	q	q
Dementia/Alzheimer's	q	q	q	q	q	q	q
Diabetes	q	q	q	q	q	q	q
Gestational Diabetes	q	q	q	q	q	q	q
Impaired Fasting Glucose	q	q	q	q	q	q	q
Insulin Resistance	q	q	q	q	q	q	q
Maturity onset Diabetes (MODY)	q	q	q	q	q	q	q
Pre-Diabetes	q	q	q	q	q	q	q
Type 1 Diabetes	q	q	q	q	q	q	q
Type 2 Diabetes	q	q	q	q	q	q	q
Colon Polyp	q	q	q	q	q	q	q
Crohn's Disease	q	q	q	q	q	q	q
Familial adenomatous polyposis (FAP)	q	q	q	q	q	q	q
Gastrointestinal Disorder	q	q	q	q	q	q	q
Irritable Bowel Syndrome	q	q	q	q	q	q	q
Ulcerative Colitis	q	q	q	q	q	q	q
Lynch Syndrome	q	q	q	q	q	q	q
Angina	q	q	q	q	q	q	q
Coronary Artery Disease	q	q	q	q	q	q	q
Heart Attack	q	q	q	q	q	q	q
Heart Disease	q	q	q	q	q	q	q
Unknown Heart Disease	q	q	q	q	q	q	q
Hypertension	q	q	q	q	q	q	q
Cystic Kidney Disease	q	q	q	q	q	q	q
Chronic Kidney Disease (assoc. Diabetes Type 2)	q	q	q	q	q	q	q
Congenital Kidney Disease	q	q	q	q	q	q	q
Kidney Nephrosis	q	q	q	q	q	q	q
Nephritis	q	q	q	q	q	q	q
Nephrotic Syndrome	q	q	q	q	q	q	q

Other Kidney Disease	q	q	q	q	q	q	q
Unknown Kidney Disease	q	q	q	q	q	q	q
Asthma	q	q	q	q	q	q	q
COPD	q	q	q	q	q	q	q
Chronic Bronchitis	q	q	q	q	q	q	q
Chronic Lower Respiratory Disease	q	q	q	q	q	q	q
Emphysema	q	q	q	q	q	q	q
Influenza	q	q	q	q	q	q	q
Pneumonia	q	q	q	q	q	q	q
Osteoporosis	q	q	q	q	q	q	q
Anxiety	q	q	q	q	q	q	q
ADHD	q	q	q	q	q	q	q
Autism	q	q	q	q	q	q	q
Bipolar Disorder	q	q	q	q	q	q	q
Dementia	q	q	q	q	q	q	q
Depression	q	q	q	q	q	q	q
Eating Disorder	q	q	q	q	q	q	q
Mental Disorder	q	q	q	q	q	q	q
OCD	q	q	q	q	q	q	q
Panic Disorder	q	q	q	q	q	q	q
Personality Disorder	q	q	q	q	q	q	q
PTSD	q	q	q	q	q	q	q
Schizophrenia	q	q	q	q	q	q	q
Social Phobia	q	q	q	q	q	q	q
Septicemia	q	q	q	q	q	q	q
Stroke/Brain Attack	q	q	q	q	q	q	q
Sudden Infant Death Syndrome	q	q	q	q	q	q	q

PATIENT HISTORY

Please describe your past accidents:

1.Accident: ____qJob qAuto qOther Date: ________________

2.Accident: ____qJob qAuto qOther Date: ________________

3.Accident: ____qJob qAuto qOther Date: ________________

Please describe your past surgeries:

1. Surgery: ____ Date: ________________
2. Surgery: ____ Date: ________________
3. Surgery: ____ Date: _______________

Do you have any implants? qYes qNo If yes, please describe ____

Are you currently pregnant? qYes qNo If yes, please list your due date: _____________________

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	q	Allergies	q	Anemia	q	Arthritis	q
Asthma	q	Back Pain	q	Bladder Trouble	q	Bone Fracture	q
Cancer	q	Chest Pain	q	Concussion	q	Constipation	q
Convulsions	q	Depression	q	Diarrhea	q	Dislocated Joints	q
Epilepsy	q	Fibromyalgia	q	German Measles	q	Headache	q
Heart Trouble	q	Hepatitis	q	Herniated Disk	q	High Blood Pressure	q
High Cholesterol	q	HIV/ARC	q	Kidney Disorder	q	Loss of Bowel Control	q

Lung Disease	q	Menstrual Cramps	q	Migraine Headaches	q	Multiple Sclerosis	q
Muscular Dystrophy	q	Neck Pain	q	Nervousness	q	Numbness	q
Osteoporosis	q	Parkinson's disease	q	Pinched Nerve	q	Polio	q
Poor circulation	q	Reproductive disorder	q	Rheumatic Fever	q	Rheumatism	q
Rheumatoid Arthritis	q	Scarlet Fever	q	Scoliosis	q	Serious Injury	q
Sinus Trouble	q	Stroke	q	Thyroid Problems	q	Tuberculosis	q
Tumors or Growths	q	Ulcers	q	Venereal Disease	q	________________	q

SYMPTOMS			
On the following pages you will be asked to choose your symptoms from this list.			
Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain

IMPAIRED ACTIVITIES			
To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.			
Computer Use (extended)	Computer Use (Short time)	Concentrating	Cycling
Desk Work	Drawing	Driving	Exercise
Lying Down	Piano	Reading	Running
Sitting	Standing	Staying Asleep	Using the Phone
Walking	Yard Work	Bathing	Bending

Caring for Infirm Person	Cervical Range of Motion	Child Care	Climbing Stair
Falling Asleep	Dressing	Golf	Hair Care
Kneeling	Lifting	Lifting Children	Lifting/Carrying Groceries
Looking over Shoulder	Lying Down	Needlework	Pet Care
Sexual Activities	Shaving	Sitting	Swimming

<table>
<tr><th colspan="4">SYMPTOMS</th></tr>
<tr><td colspan="4">Please fill out the form below to describe your current symptoms.</td></tr>
<tr><th colspan="4">SYMPTOM 1</th></tr>
<tr><td colspan="4">Symptom (choose ONE from list on previous page):</td></tr>
<tr><td colspan="4">Pain rating (1-10, with 10 being worst imaginable):
q1 q2 q3 q4 q5 q6 q7 q8 q9 q10</td></tr>
<tr><td colspan="4">Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):</td></tr>
<tr>
<td rowspan="2">Pain Quality:
qAching
qBurning
qCramping
qDeep
qDiffuse
qDull
qNumbness
qRadiating
qSharp
qShooting
qStiffness
qTight
qTingling</td>
<td>Pain Frequency:
qConstant
qFrequent
qIntermittent
qOccasional</td>
<td>Pain radiates into:
qLeft Arm
qLeft Foot
qLeft Hand
qLeft Leg
qLeft Shoulder
qRight Arm
qRight Foot
qRight Hand
qRight Leg
qRight Shoulder
qOther: __________</td>
<td>Pain Cause:
qA Fall
qWork Injury
qAuto Accident
qIllness
qLifting Injury
qUnknown
qGradual Onset</td>
</tr>
<tr>
<td>Pain Pattern:
qBetter in Morning
qBetter in Afternoon
qBetter in Evening
qWorse in Morning
qWorse in Afternoon
qWorse in Evening
qConsistent
qUnchanged</td>
<td>What has been done before to treat this symptom?
qAcupuncture
qPrescription medicine
qMassage
q Surgery
qOTC Medicines</td>
<td>Pain Duration:
q_____Day(s)
q_____Week(s)
q_____Month(s)
q_____Year(s)</td>
</tr>
</table>

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 2			
Symptom (choose ONE from list on previous page):			
Pain rating (1-10, with 10 being worst imaginable): q1 q2 q3 q4 q5 q6 q7 q8 q9 q10			
Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):			
Pain Quality:	**Pain Frequency:**	**Pain radiates into:**	**Pain Cause:**
qAching qBurning qCramping qDeep qDiffuse qDull qNumbness qRadiating qSharp qShooting qStiffness qTight qTingling	qConstant qFrequent qIntermittent qOccasional	qLeft Arm qLeft Foot qLeft Hand qLeft Leg qLeft Shoulder qRight Arm qRight Foot qRight Hand qRight Leg qRight Shoulder qOther: ___________	qA Fall qWork Injury qAuto Accident qIllness qLifting Injury qUnknown qGradual Onset
	Pain Pattern:	**What has been done before to treat this symptom?**	**Pain Duration:**
	qBetter in Morning qBetter in Afternoon qBetter in Evening qWorse in Morning qWorse in Afternoon qWorse in Evening qConsistent qUnchanged	qAcupuncture qPrescription medicine qMassage q Surgery qOTC Medicines	q______Day(s) q______Week(s) q______Month(s) q______Year(s)

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 3

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):
q1 q2 q3 q4 q5 q6 q7 q8 q9 q10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:	Pain Frequency:	Pain radiates into:	Pain Cause:
qAching qBurning qCramping qDeep qDiffuse qDull qNumbness qRadiating qSharp qShooting qStiffness qTight qTingling	qConstant qFrequent qIntermittent qOccasional	qLeft Arm qLeft Foot qLeft Hand qLeft Leg qLeft Shoulder qRight Arm qRight Foot qRight Hand qRight Leg qRight Shoulder qOther: ___________	qA Fall qWork Injury qAuto Accident qIllness qLifting Injury qUnknown qGradual Onset
	Pain Pattern: qBetter in Morning qBetter in Afternoon qBetter in Evening qWorse in Morning qWorse in Afternoon qWorse in Evening qConsistent qUnchanged	**What has been done before to treat this symptom?** qAcupuncture qPrescription medicine qMassage q Surgery qOTC Medicines	**Pain Duration:** q______Day(s) q______Week(s) q______Month(s) q______Year(s)

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 4			
Symptom (choose ONE from list on previous page):			
Pain rating (1-10, with 10 being worst imaginable): q1 q2 q3 q4 q5 q6 q7 q8 q9 q10			
Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):			
Pain Quality:	**Pain Frequency:**	**Pain radiates into:**	**Pain Cause:**
qAching qBurning qCramping qDeep qDiffuse qDull qNumbness qRadiating qSharp qShooting qStiffness qTight qTingling	qConstant qFrequent qIntermittent qOccasional	qLeft Arm qLeft Foot qLeft Hand qLeft Leg qLeft Shoulder qRight Arm qRight Foot qRight Hand qRight Leg qRight Shoulder qOther: ___________	qA Fall qWork Injury qAuto Accident qIllness qLifting Injury qUnknown qGradual Onset
	Pain Pattern:	**What has been done before to treat this symptom?**	**Pain Duration:**
	qBetter in Morning qBetter in Afternoon qBetter in Evening qWorse in Morning qWorse in Afternoon qWorse in Evening qConsistent qUnchanged	qAcupuncture qPrescription medicine qMassage q Surgery qOTC Medicines	q______Day(s) q______Week(s) q______Month(s) q______Year(s)

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 5

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):
q1 q2 q3 q4 q5 q6 q7 q8 q9 q10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:	Pain Frequency:	Pain radiates into:	Pain Cause:
qAching qBurning qCramping qDeep qDiffuse qDull qNumbness qRadiating qSharp qShooting qStiffness qTight qTingling	qConstant qFrequent qIntermittent qOccasional	qLeft Arm qLeft Foot qLeft Hand qLeft Leg qLeft Shoulder qRight Arm qRight Foot qRight Hand qRight Leg qRight Shoulder qOther: ___________	qA Fall qWork Injury qAuto Accident qIllness qLifting Injury qUnknown qGradual Onset
	Pain Pattern:	**What has been done before to treat this symptom?**	**Pain Duration:**
	qBetter in Morning qBetter in Afternoon qBetter in Evening qWorse in Morning qWorse in Afternoon qWorse in Evening qConsistent qUnchanged	qAcupuncture qPrescription medicine qMassage q Surgery qOTC Medicines	q______Day(s) q______Week(s) q______Month(s) q______Year(s)

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 6

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):
q1 q2 q3 q4 q5 q6 q7 q8 q9 q10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:	Pain Frequency:	Pain radiates into:	Pain Cause:
qAching qBurning qCramping qDeep qDiffuse qDull qNumbness qRadiating qSharp qShooting qStiffness qTight qTingling	qConstant qFrequent qIntermittent qOccasional	qLeft Arm qLeft Foot qLeft Hand qLeft Leg qLeft Shoulder qRight Arm qRight Foot qRight Hand qRight Leg qRight Shoulder qOther: ___________	qA Fall qWork Injury qAuto Accident qIllness qLifting Injury qUnknown qGradual Onset
	Pain Pattern:	**What has been done before to treat this symptom?**	**Pain Duration:**
	qBetter in Morning qBetter in Afternoon qBetter in Evening qWorse in Morning qWorse in Afternoon qWorse in Evening qConsistent qUnchanged	qAcupuncture qPrescription medicine qMassage q Surgery qOTC Medicines	q______Day(s) q______Week(s) q______Month(s) q______Year(s)

Pain aggravated by:		Pain relieved by:	
qBending	qCoughing	qExercise	qHeat
qDriving	qExercising	qIbuprofen	qIce
qGetting up/down	qHouse Work	qKnees Bent Up	qLifting
qIncreased Activity	qLifting	qLying Down	qMedication
qLooking down	qLying down	qNo Movement	qReaching
qOverhead activities	qPreparing food	qResting	qSitting
qReaching	qResting	qStanding	qStretching
qSitting	qSneezing	qSupport	qTurning Head
qStanding	qTwisting	qWalking	
qTyping	qWalking		

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?