

Name _____ Date _____
 Address _____ zip code _____
 Home telephone _____ Cell _____ Work Telephone _____
 DOB _____ Sex _____ Email _____
 Referral Source _____ Primary Care Physician _____
 May I send a thank you note to your referral source? _____
 Emergency Contact _____ Relationship _____
 Telephone _____
 Hospital Preference _____
 Employer _____
 Address _____

Medical Information Please circle any that apply:

- | | |
|------------------------------|------------------------------|
| Allergies/Asthma | Low back pain |
| Arthritis – Osteo/Rheumatoid | Lupus |
| Bladder problems | Migraines, Tension headaches |
| Bowel problems | Multiple Sclerosis |
| Cancer | Osteoporosis |
| Carpal Tunnel | Phlebitis/Thrombosis |
| Diabetes | Sinusitis |
| Drug and Alcohol Dependency | Skin Disorders |
| Epilepsy | Stroke |
| Fibromyalgia | TMJ Dysfunction |
| Glaucoma | Ulcers |
| Head/Neck Trauma | Varicose Veins |
| Heart Disease | |
| Hepatitis | Rest / Night pain |
| Herpes | Recent Weight loss |
| High Blood Pressure | Recent Infection |
| HIV infection | Fever or Chills |
| Immune Suppression | |

Are there any other health issues I need to know about? _____

Do you exercise regularly? _____ If so, how? _____

Previous treatment (Physical Therapy, Chiropractor, Acupuncture) _____

Surgery (Type/Date) _____

Meals per day _____ Do you consume caffeine? _____ If so, how much? _____

Do you smoke? _____ If so, how much? _____

Do you consume alcohol? _____ If so, how much? _____

Tests taken – MRI _____ CT Scan _____ X-ray _____ Others _____

Pain Level (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Location of Pain _____

Medications _____

Consent for treatment: *please sign below*

