

WELCOME

REASON FOR TODAY'S VIST

Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain? Yes No Rate your pain on the following scale: 0 1 2 3 4 5 6 7 8 9 10

Did your injury occur during: Work Sports/Play Auto Accident Routine/Household Activity

When did your condition/accident occur? _____ Where did it occur? _____

Please explain what happened? _____

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep or Daily routine? If so, how? _____

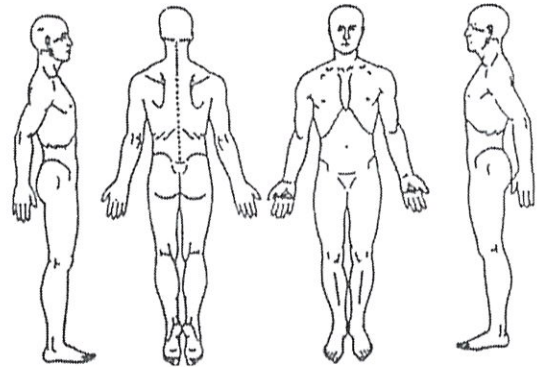
Has this or something similar happened in the past? Yes No

Explain: _____

USING THE ADJACENT CHART, PLEASE CIRCLE ALL AFFECTED AREAS

Have you been treated by a Medical Physician for this condition? Yes No

If so, Where? _____



Health History

Are you taking any of the following medications?

Nerve pills Pain Killers (including aspirin) Muscle Relaxers Blood Thinners Tranquilizers Insulin

Other: _____

Do you have or have you had any of the following diseases, medical conditions, or procedures

Y N Heart Attack/Stroke	Y N Heart surg./Pacemaker	Y N Heart murmur	Y N Congenital Heart Defect
Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe/Frequent Headaches
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants
Y N Mitral Valve Prolapse	Y N HIV+/AIDS/ARC	Y N Anemia/Diabetes	Y N Kidney Problems
Y N Tuberculosis	Y N Arthritis		

Please list any surgeries with dates and/or any other serious medical conditions not listed above: _____

List any serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take vitamins or supplements? Yes No Do you exercise? Yes No If yes, hours per week: _____

Do you smoke? Yes No If yes, how much? _____ For how long? _____

Are you wearing: Shoe lifts Inner soles Arch Supports Are you dieting? Yes No If yes, for how long? _____

*FOR WOMEN: Are you taking Birth Control? Yes No Are you Nursing? Yes No

Are you Pregnant? Yes No If yes, how many weeks? _____

I understand the above information and guarantee this from was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Or Guardian Signature: _____ Date: _____