

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number Where You Can Always Be Reached: \_\_\_\_\_ Cell: \_\_\_\_\_

E Mail: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Partner Status: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

How Did You Find My Practice (Referred By): \_\_\_\_\_ Physician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

What Therapies Have You Tried? \_\_\_\_\_

Pain Scale: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Describe The Pain: \_\_\_\_\_

What Makes The Pain Worse & Better: \_\_\_\_\_

Medications & Supplements Inventory: \_\_\_\_\_

**PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW**

