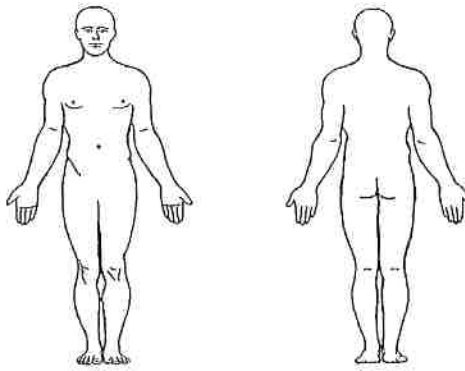




Please indicate on the diagram above, where the areas with symptoms are located.

Patient Name: _____ DOB: _____

Referring Physician: _____ Family Physician: _____

Date of injury or Onset of symptoms? _____ Cause of Injury? _____

Frequency of your symptoms? Constant Intermittent Getting better Worsening Staying the same

On a Scale of 1-10 (10 being the highest), please rate your current level of pain? Now _____ Best _____ Worst _____

What movements, postures or activities increase your symptoms? _____

Does anything decrease your symptoms? _____

Has this condition caused any falls? Y or N Is this a work injury? Y or N

Previous treatment for this condition? PT OT Massage Chiropractic Injection Surgery Exercise Medication Acupuncture

If treatment was administered was it helpful? _____

Special Tests for this condition: X-Ray MRI CT Scan ENG Hearing Test Blood Work EMG Biopsy Ultrasound

Please List any previous Surgeries:

Past Medical History: Diabetes- Heart Disease- Stroke- COPD- Vascular Disease- Infection- Fibromyalgia- Parkinson's- MS- Whiplash- Concussion- Stomach Problems- Arthritis- Osteoporosis- Cancer- Vertigo- Motion Sickness- Auto immune Disease- Neuropathy- Muscle Atrophy- Acid Reflux- Headaches/Migraines

Medications: pain, anti-inflammatory, muscle relaxers, nausea, allergy, nerve, anxiety, blood pressure, heart, stomach, vitamins, herbals, topical creams or, over the counter

Goals for therapy: _____

Patient Signature _____ Date _____