

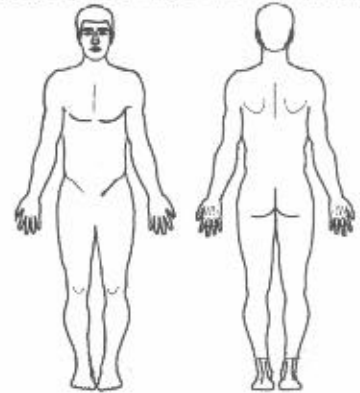
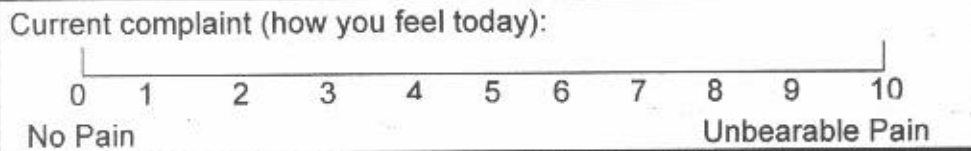
Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____



How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100%
Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: None Apply

- | No | Yes | Condition |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma |

- | No | Yes | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____