

Information Update

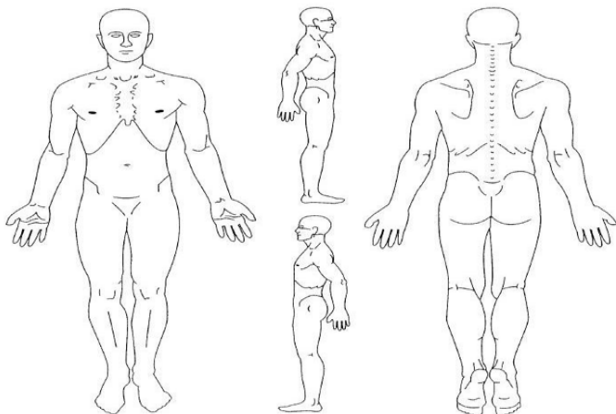
Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**Current Condition Information**

When did your condition begin? \_\_\_\_\_  
 Is your condition due to an Automobile Accident?  Yes  No  
 Is your condition due to an Employment Related Injury?  Yes  No      If so, have you reported it?  Yes  No  
 Other Doctors seen for this condition? \_\_\_\_\_

**By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:**

**N=Numbness**                      **B=Burning**  
**S=Sharp**                         **T=Tingling**                      **A=Dull Ache**



Have you had the same or similar symptoms before?  Yes  No

Date of prior condition \_\_\_\_\_

List chief symptoms in order of severity:

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_

Average Pain Intensity for the last 24 hours:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Family Physician \_\_\_\_\_

May we forward our findings to your doctor?  Yes  No

Current Medications \_\_\_\_\_  
 \_\_\_\_\_

Allergies (Medicine, Food, Environment) \_\_\_\_\_  
 \_\_\_\_\_

Previous Surgeries \_\_\_\_\_

Do you have a PERSONAL history of:

- Cancer     Diabetes     Heart     Disease     Stroke

Other serious illnesses \_\_\_\_\_

Check all symptoms that apply to you:

- Headache                       Tingling/numbness in arms/hands                       Chest Pain                       Unexplained weight loss
- Neck Pain/Stiffness         Tingling/numbness in legs/toes                       Knee Pain                       Fatigue
- Back Pain/Stiffness         Loss of balance/dizziness                       Hip Pain                       Night Sweats
- Shoulder Pain                 Shortness of breath                       Fever                       Blood in Urine
- Night Pain                       Pain unrelieved by rest

Other \_\_\_\_\_

For women: Are you pregnant?  Yes  No

Are you taking birth control?  Yes  No