CASE NO. _____ PATIENTS NAME _____

ADDRESS _____

REFERRED BY:

TELEPHONE # (_____)_____ (Name of Physician) _____

DATE OF BIRTH _____ SEX _____ OCCUPATION _____

DATE:	HT:	WT:	AGE:

What parts of your body are you being seen for?

Describe your injury (date of injury, how your were injured) or pain (when did pain begin, how long have you had pain)

What treatment have you had?

What testing have you had ?

Is there any prior history of the same or similar complaints? If yes, please describe.

List any allergies to medications:

List any fractures/sprains:

List any surgeries:

List or circle medical problems:

Hypertension	**Diabetes**	**Asthma**	**Epilepsy / seizure disorder**
Heart attack	**Migraines**	**Stroke**	**Cardiac disease**
Ulcers	**Cancer**	**Anemia**	**Thyroid disease**

List all current medications:

Do you smoke ?

Do you drink alcohol ?