DATE: _____/_____/_____

NAME: _____

1. **Please State the Main Reason You Are Here Today:**

   _____

2. **When did you first notice any symptoms (Date of injury if known)?**

   _____

3. **Where did the injury or illness occur and how?**

   _____

4. **Have you received treatment for similar symptoms before visiting this office?** ☐No ☐Yes

If yes, please provide name/address of **Physician, Chiropractor, Pain management, or Physical Therapy.**

Name and Address of Doctor: _____Phone: _____
Treatment received:_____Fax:_____

5. Have you had any **Surgeries**? ☐No ☐Yes—If yes, list operations, date, doctor/hospital:

   Surgery: Date/Doctor/Hospital:_____

Pain diagram

Mark the location of your pain on the body

XXX where you have pain.

OOO where you have numbness.

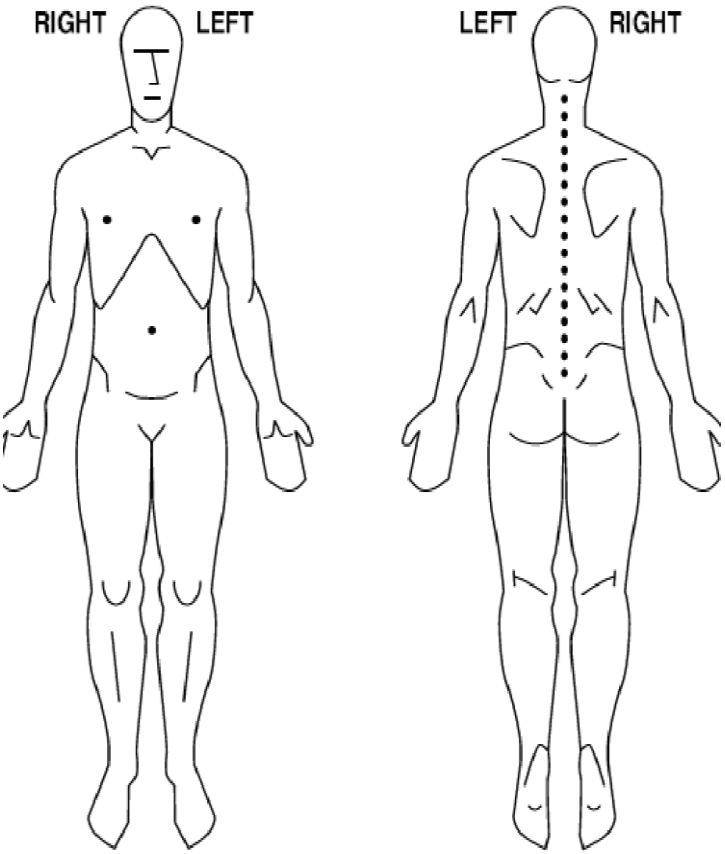
ZZZ where you have weakness.

Mark where your pain is TODAY.

No pain ***Worst***

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10



I have noted any changes made and to the best of my knowledge, I believe all information to be true.

Patient Signature: _____