

Have you ever had any imaging performed?

X-Ray: \_\_\_\_\_ MRI: \_\_\_\_\_ CT Scan: \_\_\_\_\_ Doppler: \_\_\_\_\_ Ultrasound: \_\_\_\_\_

Do you know the results? \_\_\_\_\_

Please Circle all of the following conditions that pertain to you now or in the past:

Anxiety / Depression	Arthritis	Asthma	Cancer	Chest Pain/Heart Attack
Circulatory Problems	Dizziness/Fainting	Epilepsy/Seizures	Hearing Loss	Heart Disease
High Blood Pressure	Lung Disease	Stroke	Thyroid Problems	
Use of Alcohol/Drugs: ___1-3x/week	___3-7x/week	___7-12x/week	___12+/week	
Allergies (please list): _____				

Do you currently have or have you had in the past any of the following?

Osteoporosis / Osteopenia:	Yes	No	Cardiac/Heart Problems:	Yes	No
Cancer:	Yes	No (if yes, type) _____	Pacemaker/Defibrillator:	Yes	No
Any unexplained night pain:	Yes	No	Any unexplained weight loss:	Yes	No

Have you fallen more than once in the past year? Yes No How many times? \_\_\_\_\_

Have you had any other healthcare treatments related to your injury?

Physical Therapy: \_\_\_\_\_ Chiropractics: \_\_\_\_\_ Injections: \_\_\_\_\_ Massage: \_\_\_\_\_ Acupuncture: \_\_\_\_\_

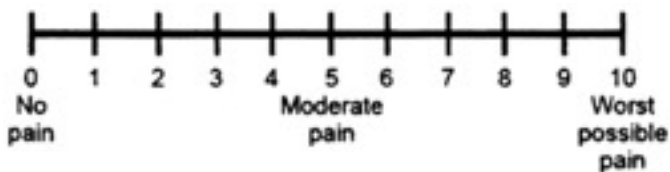
Date of Injury or Onset of Symptoms: \_\_\_\_\_ Cause of injury (if known): \_\_\_\_\_

When is your pain most aggravating?	When is your pain least aggravating?
Morning: _____ Evening: _____ Constant: _____	Morning: _____ Evening: _____ Constant: _____

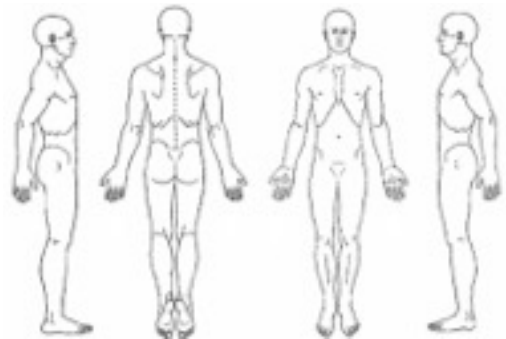
What makes your pain worse?

What makes your pain better?

On a scale of 0 - 10, 0 meaning *no pain*, and 10 meaning *you should be in the Emergency Room*, please circle the number that best describes your symptoms:



Location of symptoms: please indicate on diagram  
000=Numb/tingling      XXX=Sharp Pain  
---=Burning              +++=Aching



I understand that I am responsible to inform the physical therapist of any health problems and allergies that I have, as well as any drugs or medications I am taking. I verify all of the provided information is accurate.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*How did you hear about us? (Please circle all applicable.)*

Family Doctor	Chiropractor	Dentist	Other Physician: _____	Friend/Family
Social Media/Facebook	Print Ad/Billboard	Search Engine/Internet	Other: _____	