



Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

What is the primary reason for your visit?

 Acute Pain (Recent Onset)

 Chronic Pain (Lasting at least three months)

Date of Onset? _____

What caused your pain?

- Motor Vehicle Accident
- Work Accident
- Sports Injury
- Congenital/Birth
- Other: _____

Have you seen other doctors for this? Y N

 Primary Care ER Chiro Physical T

If yes, Diagnosis: _____

What treatment or medication have you had for your pain?

Where is your pain?	Severity of Pain (1-10)
• Headache	1...3...6 7 8 9 10
• Neck	1...3...6 7 8 9 10
• Upper Back	1...3...6 7 8 9 10
• Mid Back	1...3...6 7 8 9 10
• Lower Back	1...3...6 7 8 9 10
• Knee R L	1...3...6 7 8 9 10
• Ankle R L	1...3...6 7 8 9 10
• Foot R L	1...3...6 7 8 9 10
• Shoulder R L	1...3...6 7 8 9 10
• Elbow R L	1...3...6 7 8 9 10
• Wrist R L	1...3...6 7 8 9 10
• Hand R L	1...3...6 7 8 9 10
• Abdomen	1...3...6 7 8 9 10
• Other _____	1...3...6 7 8 9 10

What is your level of pain now? 1---5----10

Does the pain keep you from doing what you want or need to do? Y N

What is the HIGHEST level of pain you have had since it began? 1---5----10

What is the HIGHEST level of pain you have had in the past week? 1---5----10

For Women of Childbearing Potential Only

- Are you, or could you be, pregnant? Y N
- If yes, do you plan to breastfeed? Y N
- If not pregnant, do you plan on becoming pregnant in the near future? Y N
- If you are not pregnant and do not have plans for a pregnancy, what form of prevention do you practice?



Current Medications:

Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____

Current Supplements:

Supplement: _____	Dose: _____	Frequency: _____
Supplement: _____	Dose: _____	Frequency: _____
Supplement: _____	Dose: _____	Frequency: _____

Known Drug Allergies:

Medication: _____	Reaction: _____	Last Taken: _____
Medication: _____	Reaction: _____	Last Taken: _____
Medication: _____	Reaction: _____	Last Taken: _____

If this is the result of an accident:

- **Have you contacted your insurance carrier, e.g., auto insurance for a motor vehicle accident?** Y N
- **Have you contacted an attorney to represent you in a legal action for this?** Y N
- **Do you desire to defer payment for our services until the accident has been settled** Y N

If yes, you must provide us with the contact information for your insurance representative or attorney

Signature of Patient

Signature

Date