

Name: _____



Date: _____

Briefly describe your current injury/symptoms: _____

Date of onset and cause of injury/symptoms: _____

Have you recently experienced any numbness, tingling, altered sensation in the arms, legs, trunk, or face? If so, where? _____

List any medications you are currently using and **for what purpose** (or provide the front office with a list of medications to photo copy): _____

Circle any of the medical conditions that apply to you: **Allergies, Pregnancy, Hemophilia, Anemia, Ulcer, GI disorder, Tuberculosis, Psychological disorder (i.e. Depression, Dementia, etc), Headaches, Severe Dizziness, Double vision, Kidney/Liver problems, Skin disease, Osteoarthritis, Rheumatoid arthritis, Cancer, Circulatory problems (i.e. PVD, clots, etc), High blood pressure, Diabetes, Pacemaker, Heart problems, Osteoporosis, Parkinson's, Alzheimer's, Multiple Sclerosis, Metal implants, Stroke, COPD (lung disorder), Back Disorder, Sciatica, Neuropathy, Nerve Disorder, or Pinched nerve**

Other medical conditions/disorders: _____

List any major surgeries and date: _____

List any brace/orthotic/ergonomic device you currently utilize: _____

List and date any tests relating to your present symptoms (ie X-ray, MRI, CT scan, EMG test, bone scan, etc) : _____

What activities aggravate your symptoms? _____

What activities relieve your symptoms? _____

Approximate the amount of time you can tolerate: sitting _____, standing _____, and walking _____.

Occupation: _____

Next Doctor's Visit: _____

What functional activities (ie hobbies, home activities, sports, etc.) do you wish to resume?
