Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Personal Contact Information **Today's Date** ___________

Name_______________________________________ Age _______ Date of Birth___________

Address _______________________ City _______________ State _______ Zip Code___________

Home Phone______________ Height _________ Weight _________ Sex (Circle one): M F

Work Phone ______________ Employer ___________________________________

Cell Phone______________ Occupation ___________________________________

Email ____

Marital Status (Circle one): Single Partnered Married Divorced Widowed Number of Children _____

Emergency Contact: Name ______________________________ Phone ______________

Relationship to Patient ______________________________

Referred by: ____

History of Present Illness

Describe the symptoms that you are experiencing, their location(s), and types of pain:_______________

____

____

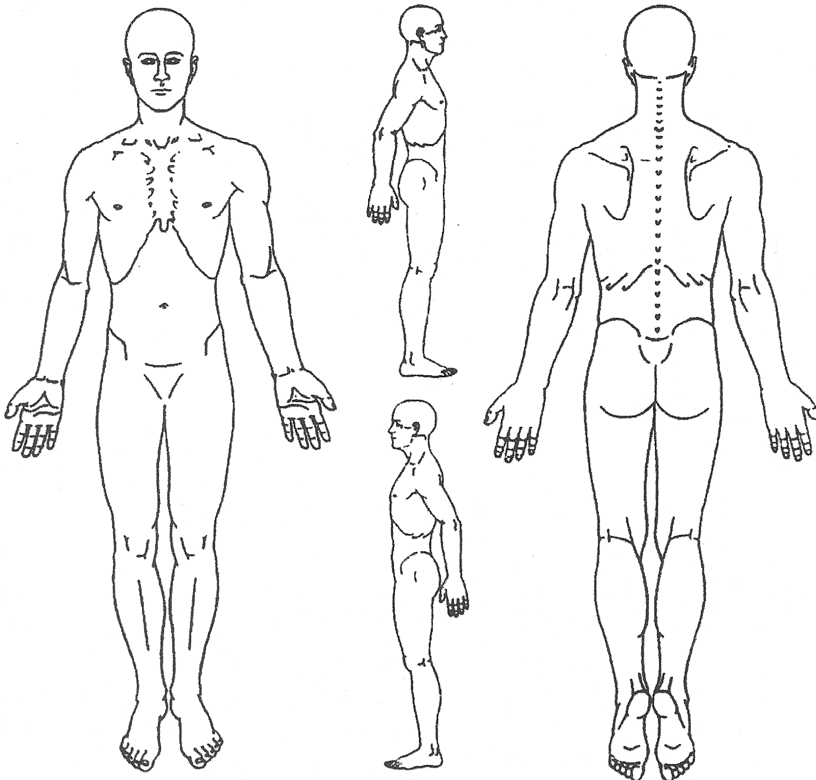
____

When did you first notice these symptoms?_______________________________

Has this happened before? (Circle one) Yes No If Yes, When?___________________

Mark the areas where you feel the described sensations on the pictures below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
---------	00000	XXXXX	*****	//////



Neck - Shoulder - Arm Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——→ 10
No pain Severe pain

Mid Back Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——→ 10
No pain Severe pain

Low Back and Leg Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——→ 10
No pain Severe pain

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Was the pain caused by (Check all that apply):

❏ Strain, Date of strain________________________ ❏ Mental Stress ❏ Emotional Stress

❏ Fall, Date of fall____________________________ ❏ Auto accident, Date of accident ____________________

Is this a work related accident (Circle one)? Yes No

We are not a worker's compensation provider under the State of Texas and therefore are unable to treat any work related injuries.

Have you seen another doctor for this (Circle one)? Yes No

Name of Doctor:____________________________________City:______________________ X-Rays ____________

Treatment:____ MRI ____________

Results____ CAT Scan__________

____

Are you still under this doctor's care (Circle one)? Yes No

When was your last physical? ________________________Results____

Medical History

Do **You** have any history of (Check all that apply):

❏ Heart disease	❏ Cancer	❏ Stroke	❏ Diabetes
❏ Hypertension	❏ Low blood sugar	❏ Low blood pressure	❏ Liver disease
❏ Dementia	❏ Alzheimer's	❏ Parkinson's	❏ Concussion
❏ Head injury	❏ Depression	❏ Mental illness	❏ Other __________________

Elaborate on any **Family** history of the above: ____

____

____

Have you ever had any broken bones? ❏ Yes ❏ No

Which bone(s) and when? ____

Any long-term effects? ____

Have you ever had any surgeries? ❏ Yes ❏ No

Please list any surgical procedures and their respective dates: _______________________________________

____

When was your last physical exam? ____

Results:____

____

Results of latest lab work? ____

Nutrition and Exercise History

Do you smoke? ❏ Yes ❏ No

Have you ever smoked? ❏ Yes ❏ No If Yes, Cessation date ______________________________________

Do you drink Alcohol? ❏ Yes ❏ No If Yes, How much and how often?____________________________

Are you a Vegetarian? ❏ Yes ❏ No If Yes, What kind? ____

How many meals do you eat per day?___________ How often do you eat out? ______________________________

What type of food do you eat when eating out?____

Do you exercise regularly? ❏ Yes ❏ No If Yes, What kind of exercise and how often? ___________________

____

List all medications, vitamins and supplements that you are currently taking: _____________________________

____

____