

Date: _____

PATIENT MEDICAL INFORMATION

Name _____

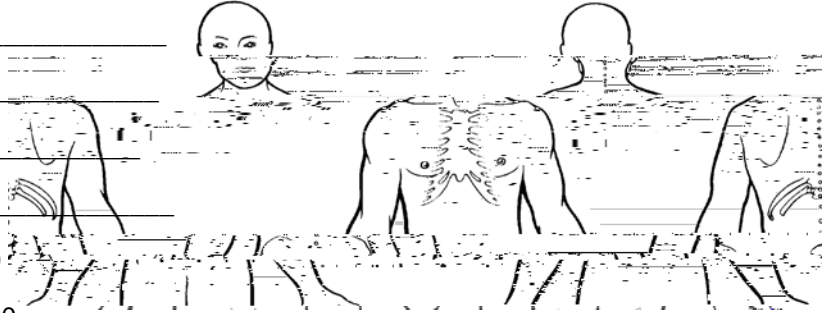
Occupation _____

Current work status/duties _____

Use the scale below pain has been in the past 48 hours ___/10

The worst your pain has been in the past 48 hours ___/10

History of Current Condition



Give a brief description of the problem(s) for which you are seeking therapy: _____

When did this problem begin? _____

Treatment received so far for this problem (chiropractic, injections, etc.): _____

Have you ever had this problem

Date: _____

Have you had any x rays, CT scans, MRI, Bone Density scan, EMG, or Nerve Conduction study recently? Yes/ No

If yes, when were the images taken and where? _____

Please list all current medications _____

Past Surgical History (list all & dates):

Surgical Procedure