

Legal Name _____ Home Phone () _____

Physical address _____ City _____ Zip _____

E-Mail address _____ Social Sec. No. _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Employer Address _____ City _____ Zip _____

Employment phone () _____ Can you receive calls at work? YES NO

CURRENT COMPLAINTS 1 _____ Date began _____

2 _____ Date began _____

3 _____ Date began _____

Treatment received for these complaints: MEDS / LAB TESTS / XRAYS / MRI / PHYSICAL THERAPY / SURGERY / NONE / OTHER

Dr.s name: _____ in city of _____ Phone () _____

How did your pain start? ACCIDENT AT HOME / ACCIDENT AT WORK / ACTIVITY AT HOME / ACTIVITY AT WORK / WOKE UP WITH IT / IT'S ALWAYS BEEN THERE / OTHER _____

Your pain bothers you most when you SIT / STAND / WALK / SLEEP / DRIVE / BEND / REACH / OTHER _____

You are most comfortable when you SIT / STAND / WALK / SLEEP / DRIVE / OTHER _____

WORK ENVIRONMENT

You work _____ hours/day _____ days/week. You sit _____ % of the time. You stand _____ % of the time.

You bend _____ % of the time. You use a computer _____ % of the time. The monitor is directly in front of you YES NO.

You use a phone _____ % of the time. You use a headset YES NO. You lift approx. _____ lbs. at a time _____ times / day.

You drive _____ hours / day.

HOME ENVIRONMENT

You are home _____ days / week. You spend most of that time _____

Your recent home project has been _____

Your favorite activities are _____

For exercise you _____

You drink _____ oz. of water/day. You drink _____ cups of coffee or soda / day You drink _____ alcoholic beverages/ day.

You take these vitamins every day _____

You take these drugs every day _____ for this condition : _____

_____ for this condition : _____

_____ for this condition: _____

Who may we thank for referring you to our office? _____