Patient LEGAL Name: _____ DOB: _____/_____/_____ Age: _____

Body Part: _____ When Did This Problem Begin: _____

Have you had surgery for this injury? □Yes □No Date of Surgery: _____

Is this related to MVA (car acident)? □Yes □No State the MVA occurred? _____

Is an attorney involved in this case? □Yes □No Name of attorney: _____

Brief injury description: _____

List of current medications: _____

Please list any medical allergies: _____

Please circle any diagnostic studies you have had for your current problem:
X-Ray, MRI, CT scan. EMG/NCV, Physical Therapy: _____Where? _____

Please check if you have or had any of the following:
Every item must be checked "yes" or "no"

Arthritis	Yes___ No___	Numbness/Tingling	Yes___ No___
Asthma	Yes___ No___	Loss of Skin Sensation	Yes___ No___
Cancer	Yes___ No___	Muscular Weakness	Yes___ No___
Depression	Yes___ No___	Headaches	Yes___ No___
Diabetes	Yes___ No___	Dizziness/Vertigo	Yes___ No___
Heart Attack	Yes___ No___	Nausea/Vomiting	Yes___ No___
Heart Disease	Yes___ No___	Fever/Chills	Yes___ No___
High Blood Pressure	Yes___ No___	Unexplained Weight Loss	Yes___ No___
Kidney Disease/Stones	Yes___ No___	Bowel/Bladder Changes	Yes___ No___
Stroke	Yes___ No___	Fatigue/Shortness of Breath	Yes___ No___
Polio	Yes___ No___	Difficulty Sleeping	Yes___ No___
Seizures	Yes___ No___	Blood Clot/Emboli	Yes___ No___
Osteoporosis/Osteopenia	Yes___ No___	Pregnancy/Recent Childbirth	Yes___ No___
Do you use tobacco	Yes___ No___	Emotional Problems	Yes___ No___
Neck Injury/Surgery	Yes___ No___	Shoulder Injury/Surgery	Yes___ No___
Elbow Injury/Surgery	Yes___ No___	Back Injury/Surgery	Yes___ No___
Knee Injury/Surgery	Yes___ No___	Hip Injury/Surgery	Yes___ No___
Ankle Injury/Surgery	Yes___ No___	Hand Injury/Surgery	Yes___ No___

List any other information that would assist us in your care: _____

I certify that the above information is complete and true to the best of my knowledge.

Patient Signature **Date**