PATIENT REGISTRATION. PLEASE COMPLETE ALL ITEMS AND PRINT CLEARLY.

Height:______________

Weight:______________

Today's Date_________ /_________ /________

NAME:____DATE OF BIRTH:_____________AGE:________. ☐ MALE ☐ FEMALE

Is this claim a result of an auto accident? [] YES [] NO Date of Accident:___________________________
Is this claim a result of a work accident? [] YES [] NO Date of Accident:___________________________

Check any **SYMPTOMS** you are having [] Low Back Pain [] Neck Pain [] Mid Back Pain [] Scoliosis
[] Leg pain (R/L) [] Arm Pain (R/L) [] Shoulder Pain (R/L) [] Numbness/tingling [] Other:__________________
Bowel and Bladder Function: [] Normal [] Abnormal Explain:____

Check and **SPINE TREATMENT**: [] Physical Therapy [] Narcotic Pain Meds [] Anti-Inflammatory Meds
[] Acupuncture [] Chiropractic Care [] Epidural Injections [] Surgery :__________________________________

List all current **MEDICATIONS**:____

List any **ALLERGIES** to medications:____

Past Medical History: [] None [] Heart Disease [] Hypertension [] Diabetes [] Asthma [] Lung Disease
[] Kidney Disease [] Bleeding Disorder [] Osteoporosis [] Hepatitis/HIV [] Other:________________________

Surgical History: [] Orthopedic Surgery_________________________ [] Cardiac Stents [] C-Section
[] Hysterectomy [] Gall Bladder Surgery [] Weight Loss Surgery [] Other:________________________________

Social History: Do you smoke cigarettes [] YES [] FORMER SMOKER [] NEVER SMOKER

Do you drink alcohol [] NO [] RARELY [] OCCASIONALY [] FREQUENTLY

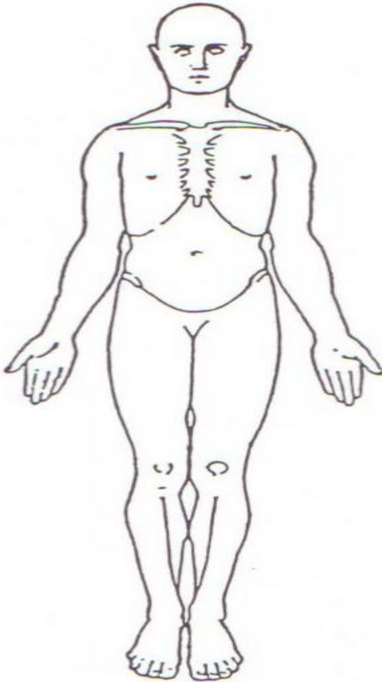
Height:_______________

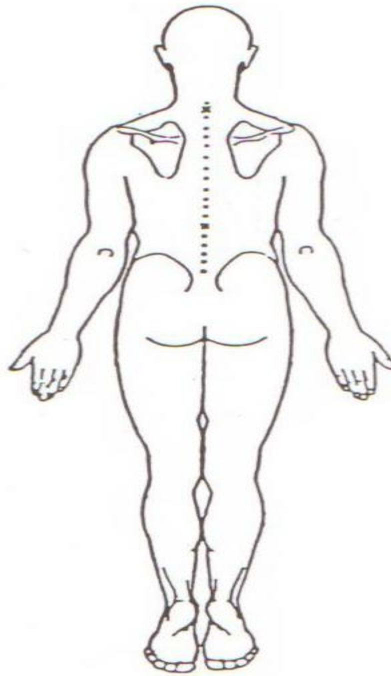
Weight:_______________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Aches	^^^^ ^^^^	Numbness	oooo oooo	Pins/Needles	==== ====	Spasm	xxxx xxxx	Stabbing	//// ////	Tender	zzzz zzzz





Mark with an X the severity of your symptoms TODAY on the line below:

____

None Most Severe

Mark with an X the severity of your symptoms in the LAST 6 MONTHS on the line below:

____

None Most Severe