New Patient Information Form

Please darken bubbles completely

PATIENT INFORMATION		
Patient Name:		**Date:**
Referring Physician:	**Height:**	**Weight:**

Date of Injury or start of symptoms: _____

How did the pain occur?

O Work injury O Motor vehicle accident O injury due to lifting O Injury due to fall

O Athletic/recreational injury O Cause unknown

For this condition have you had? O X-Ray O MRI O Epidural Injection O Cortisone Injection

Write a brief description of how the injury occurred: _____

_____

What is your primary complaint today? _____

Current Pain Scale: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are currently experiencing?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10 O 6/10 O 7/10

O 8/10 O 9/10 O 10/10

Pain Scale at its least: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain when it is at its least?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10 O 6/10 O 7/10

O 8/10 O 9/10 O 10/10

Pain Scale at itsWorst: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain when it is at its Worst?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10 O 6/10 O 7/10

O 8/10 O 9/10 O 10/10

Medical History

O	Diabetes	O	High Blood Pressure	O	Heart Disease	O	Heart Attack
O	Poor Circulation	O	Pacemaker	O	Seziures	O	Asthma
O	Emphysema/COPD	O	Osteoarthritis	O	Angina	O	Cancer

Medications (Please list names of medication you are taking and the dosage):		

Allergies (Please list the medications you are allergic to):		

Surgeries and Procedures (Please list the type of surgery or procedure and year):		

Are you? O Right Handed O Left Handed **Pregnant:** O Yes O No

I hereby certify to the best of my knowledge that the accident and/or injury information stated above is correct.

Patient/Guardian Signature _____ **Date** _____