In order to provide you with the best care, please fill in the information below.

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Are you pregnant? Y / N Due Date: _____ OB-GYN: _____

Are of the body we are treating: Low Back / Mid Back / Neck / Hip / Knee / Ankle

Shoulder / Elbow / Hand / Wrist

Other: _____

Did you have an accident: Y / N Auto / Work Date of Accident: _____

Circle if you have had any of the following medical conditions:

Asthma	Arthritis (Rheumatoid/Osteo)	Epilepsy	Pacemaker
High Blood Pressure	Cancer, type	Fainting	Allergies
Diabetes	Ulcers	Heart Disease	Blood Disorder
COPD	Immuno-Suppressed	Stroke	Artificial Joint (where)

Other:_____

Medications: _____ Occupation: _____

Pain rating today *(Please circle) (0 = no pain, 10 = worst pain)*

Headache:	0 1 2 3 4 5 6 7 8 9 10
Neck:	0 1 2 3 4 5 6 7 8 9 10
Mid-back:	0 1 2 3 4 5 6 7 8 9 10
Low-back:	0 1 2 3 4 5 6 7 8 9 10
Arm/Hands:	0 1 2 3 4 5 6 7 8 9 10
Legs/Feet:	0 1 2 3 4 5 6 7 8 9 10
	{mild}{moderate}{severe}

Please describe the **type of pain** or discomfort that you are experiencing and the **locations**? (ie: neck, hands, back, legs, etc)

Stiffness: _____ Soreness: _____

Sharp: _____ Achiness: _____

Numbness: _____ Shooting: _____

Tingling: _____ Burning: _____