

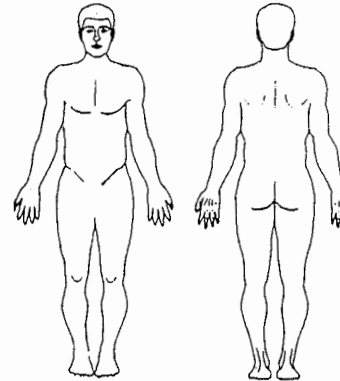
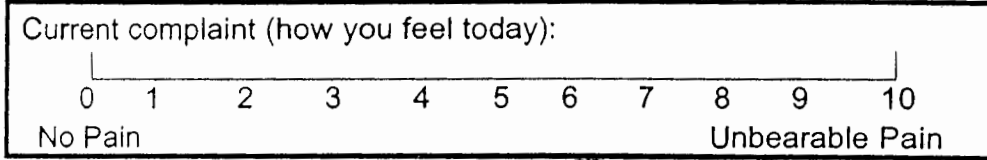
Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOM

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____



How often are your symptoms present? 0 - 25% 26 - 50% 51 - 75% 76 - 100%
Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you:

Past Present Condition

- History of Recent Infection
- Fever
- HIV/AIDS
- Diabetes
- Corticosteroid Use
- Birth Control Pills
- High Blood Pressure
- Stroke (date) _____
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer/Tumor
- Osteoporosis
- Trauma

Past Present Condition

- Prostate Problems
- Frequent Urination
- Pregnancy, # of births _____
- Abnormal Weight Gain Loss
- Epilepsy/Seizures
- Visual Disturbances
- Low/Mid Back Pain
- Neck Pain
- Arthritis
- Alcohol Use
- Tobacco Use
- Surgeries/Medications: _____

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____