

Patient Name _____ Subscriber ID # _____ Primary Language _____

Describe Your Current Problem and How It Began _____

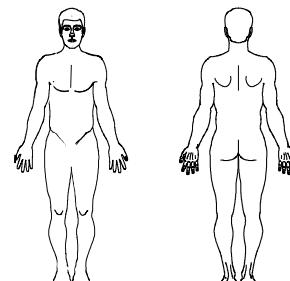
Onset date/Surgery date _____

Indicate below where you have pain or other symptoms

Is this? Work Related Auto Related N/A

How often are your symptoms present?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)



Describe the nature of your pain:

- Sharp Dull Ache Numb Shooting Burning Tingling

How is your condition changing?

- Getting Better Not Changing Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: Seeing Hearing Talking Memory Swallowing

What is your most effective learning method: Seeing Hearing Talking Doing Pictures

In general would you say your overall health right now is:

- Excellent Very Good Good Fair Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? Yes No

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Cardiac Condition
- Stroke (Date) _____
- Dizziness/Fainting
- Cancer/Tumor (Explain) _____
- Osteoporosis
- Other Health Problems (Explain) _____
- Numbness (Location) _____
- Urinary Problems
- Currently Pregnant, # Weeks _____
- Abnormal Weight Gain Loss
- Pain Unrelieved by Position or Rest
- Pain at Night
- Surgeries _____
- Tobacco Use - Type _____
Frequency _____/Day
- Current Medications _____

Who have you seen for your condition before today? No One

- Medical Doctor Massage Therapist Chiropractor Other _____
- Physical Therapist Acupuncturist Occupational Therapist Speech Therapist Athletic Trainer

What treatment did you receive and when? _____

What is your occupation? _____

I certify to the best of my knowledge, 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/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature _____ Date _____