Client Information

(Black Ink Only)

First Name: | Date of Birth: | Gender: M☐ F☐ U☐ | Date:

Last Name: | Home Number: | Cell Phone:

Address: | City: | Cell Provider: AT&T: ☐ Sprint: ☐ T-Mobile: ☐ Metro PCS: ☐ Verizon: ☐ Other ________

Email: | State: | Zip:

SSN: | Referring MD: | Family MD:

Employer: | Occupation: | Work Phone:

In case of emergency please notify...

Name: | Relationship: | Phone Number:

How did you hear about us?

MD ☐ | Instagram ☐ | Facebook ☐ | Friend ☐ | Website ☐ | Promo ☐ | Staff ☐ | Other:

Injury History Date of Injury Onset: Is this a Work Related Injury? Yes ☐ No ☐

Auto Related? Yes ☐ No ☐ | **Describe your injury or illness and how it happened:**

Have you fallen 1 or more times in the last year? Yes ☐ No ☐ ________

Have you had Physical Therapy, Home Health or Chiropractic care this year? Yes ☐ No ☐

If yes, Where? Start & End Date? Amount?

Please inform us of the following information by marking either the "Yes" or "No" box.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Metal Implants			Bowel Problems		
High/Low Blood Pressure			Communicable Diseases			Recent Weight Loss		
Pacemaker			Recent Surgery			Problems with both Arms or Legs at the same		
Chronic Headaches			Dizziness			**If yes, to any of the previous please explain and give appropriate detail**		
Kidney Problems			Cancer					
Nervous Disorders			Allergy/Sensitivity to Cold					
Hernia			Allergy/Sensitivity to Heat					
Bone Disease			Other Allergies					
Fractures			Osteoporosis					
Bladder Problems			Pregnant					
Seizures			Heart Conditions					
Pins & Needles			Circulatory Disease					

Are you currently taking any medications? Yes ☐ No ☐ If yes, which ones?

Have you had any X-rays Cat Scan, MRI's or other diagnostic tests for your recent disorder? Yes ☐ No ☐
If yes, please explain the finding as you understand them:

Is there anything else we should know about your General Health or current conditions?

Pain Rating

Please circle your major area of pain on a scale of 0 to 10.

I would **currently** rate my pain as:

No Pain		Weak Pain	Moderate Pain		Strong	Very Strong		Very, very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

The **least** amount of pain I have had in the **last 30 days** is:

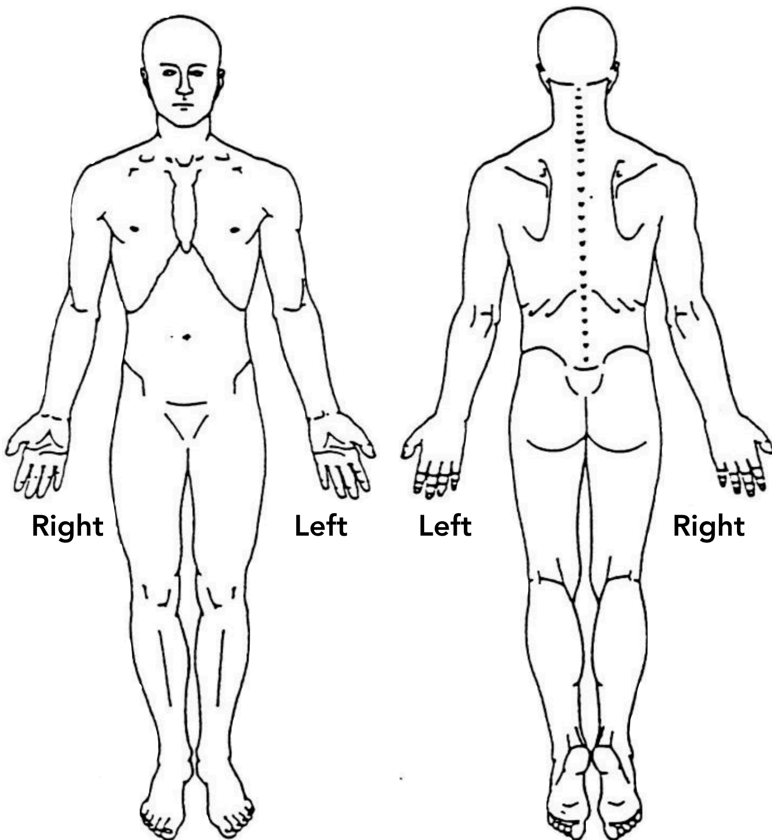
No Pain		Weak Pain	Moderate Pain		Strong	Very Strong		Very, very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

The **worst** amount of pain I have had in the **last 30 days** is:

No Pain		Weak Pain	Moderate Pain		Strong	Very Strong		Very, very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

Pain Drawing

Instructions: Please shade all areas of discomfort caused by your current injury.



Are you having any of the following?

Shooting/Sharp Pain ☐	Dull/Aching Pain ☐
Numbness ☐	Tingling ☐

Injury Info

What is the main activity that you have trouble doing because of your injury?

Since your injury/condition began, your symptoms are: Better ☐ Same ☐ Worse ☐

Over a full day, how often do you have symptoms?

Occasional ☐	Intermittent ☐	Frequent ☐	Constant ☐
10-25%	26-50%	51-80%	81-100%

How is your sleep?

Good ☐	Moderate ☐	Difficult ☐	Only With Meds ☐
Position:	Back ☐	Side ☐	Stomach ☐

What makes your injury feel Better (B), Same (S) or Worse (W)? Check each column.

Action	B	S	W	Action	B	S	W
Nothing				Twisting			
Sitting				Laying down			
Standing				Sleeping			
Walking				Rest			
Running				Sneezing			
Movement				Coughing			
Bending				Medication			
Exercise				Writing			
Kneeling				Computer			
Lifting				Other:			
Stairs							
Other:				Other:			