

Have you ever been in our office or been treated by the doctor or one of his partners? yes no
If yes, when? _____

Name: _____ Sex: male female

Date of Birth: _____ SSN: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Phone 2: _____

Emergency Contact: _____ Emergency Phone: _____

Family Physician: _____ Hospital: _____

Referred by: _____ Employer: _____

Pharmacy: _____

Married Single Divorced

Auto Accident?

Workman's Comp?

Attorney Involved?

History - Brief description of problem (main reason for your visit today?)

PREVIOUS TREATMENT

We need to know about the treatments you have already received for you current back/neck pain. IF YES, did it make your condition better or worse?

Have you had:

Chiropractic care	<input type="checkbox"/> better <input type="checkbox"/> worse
Physical therapy	<input type="checkbox"/> better <input type="checkbox"/> worse
Injections	<input type="checkbox"/> better <input type="checkbox"/> worse
Psychological consultation	<input type="checkbox"/> better <input type="checkbox"/> worse
Other: _____	<input type="checkbox"/> better <input type="checkbox"/> worse

For your current back/neck pain, please mark the boxes for the time frame that any test were done.

	>6 mo	<12 mo
X-rays	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV	<input type="checkbox"/>	<input type="checkbox"/>

PREVIOUS TREATMENT