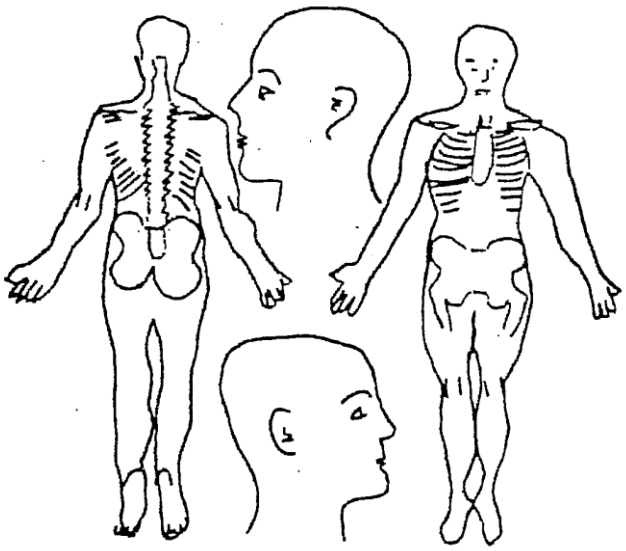
DATE: _____ NAME: _____
AGE: _____HEIGHT: _____WEIGHT: _____

MEDICAL HISTORY

CHIEF COMPLAINT: _____
_____
_____

DURATION OF PROBLEM: _____: DAYS_____: WEEKS_____: MONTHS_____: YEARS
DATE OF INJURY: _____WAS THIS A (N)____: AUTO ACCIDENT ____: WORK INJURY
____: RECREATIONAL INJURY ____: NO KNOWN REASON_____:OTHER
PLEASE DESCRIBE HOW PROBLEM BEGAN: _____
_____
_____
DRAW LOCATION OF PAIN ON DIAGRAM: CIRCLE AREA WHERE PAIN IS PRESENT, PUT AN "X"AT POINT OF GREATEST PAIN



PLEASE CHECK ALL THAT APPLY- PAIN IS:
_____: SHOOTING PAIN, _____: STABBING _____: BURNING, _____: ELECTRICITY,
_____: DULL, _____: ACHY

DO YOU HAVE NECK PAIN? _____YES _____NO

DO YOU HAVE LOW BACK PAIN OR SCIATICA? _____YES _____NO

DO YOUR HANDS TINGLE AT NIGHT? _____YES _____NO

HAVE YOU HAD ANY OPERATIONS? ____YES ____NO
OPERATION: _____ DATE: _____ SUCCESSFUL_____: YES _____: NO
OPERATION: _____ DATE: _____ SUCCESSFUL_____: YES _____: NO
OPERATION: _____ DATE: _____ SUCCESSFUL_____: YES _____: NO

WHAT MEDICATIONS, IF ANY, DO YOU TAKE AT THIS TIME?
1)_____ 2) _____ 3) _____
4)_____ 5) _____ 6) _____

DO YOU HAVE ANY ALLERGIES TO MEDICINE? _____: YES _____: NO
IF YES PLEASE LIST: _____

OVER

MEDICAL HISTORY- CONTINUED PAGE 2

ARE YOU INVOLVED IN LITIGATION OR A LAW SUIT? _____: YES _____: NO

DO YOU HAVE ANY OTHER MEDICAL ILLINESS? (I.E.- DIABETES, ASTHMA, HEART DISEASE, ETC.) : _____
_____

DO YOU SMOKE? _____: YES _____: NO
IF SO, HOW MANY PACKS PER DAY? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? _____: YES _____: NO
IF SO, HOW MUCH? _____