

**CONFIDENTIAL PATIENT DATA**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Male \_\_\_\_\_ Female

Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone\*: \_\_\_\_\_ E-mail Address\*: \_\_\_\_\_

\*Please provide this information if you are willing to allow us to contact you.

Marital Status: **Married Single Divorced Widowed**

Name of spouse or nearest relative: \_\_\_\_\_

How were referred you to our office? Dex Phone Book The Yellow Book Smart Search Patient: \_\_\_\_\_

**PLEASE DESCRIBE MAJOR COMPLAINTS (REASON FOR TODAY'S VISIT)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Date The Symptoms Began:** \_\_\_\_\_

**VISUAL ANALOGUE PAIN SCALE**

**NO PAIN 0---1---2---3---4---5---6---7---8---9---10 PAIN AS BAD AS IT COULD BE**

Please circle appropriate number on chart above

Symptoms resulting from:	Job related injury	Auto accident	Other accident	Illness
	Unknown Cause	Gradual Onset	Other _____	

If due to an accident on what date did accident occur? \_\_\_\_\_

Please describe how and where accident occurred: \_\_\_\_\_

Symptoms are worse in: **Morning Afternoon Evening**  
 Symptoms have persisted for # of \_\_\_\_\_ **Hours** \_\_\_\_\_ **Days** \_\_\_\_\_ **Weeks** \_\_\_\_\_ **Months** \_\_\_\_\_ **Years**  
 Symptoms are: **Constant or Come and Go**  
 Have you ever had this before? **YES NO**

Doctors previously seen for this condition: \_\_\_\_\_

Please **CIRCLE** the following activities that **AGGRAVATE** your condition:

Bending	Coughing	Lifting	Lying down	Reaching	Sitting	Sneezing
Standing	Straining at stool	Turning head	Walking	NONE	Other: _____	

Please **CIRCLE** the following activities that **RELIEVE** your condition: Bending Lifting  
 Lying down Reaching Sitting Standing Turning head Walking NONE Other \_\_\_\_\_

