Health Update / New Injury

Patient Name_____Date_____

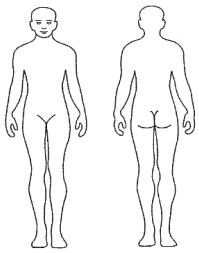
Please notify front desk of any changes to your personal information or insurance.

PATIENT CONDITION

Reason for visit_____

When did your symptoms appear? _____

Is this condition getting progressively worse ____Yes ____No



Mark an X on picture where you have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting
___Burning ___Tingling ___Cramps ___Stiffness ___ Swelling ___Other_____

_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ____Work ____Sleep ____Daily routine ____ Recreation

Activities or movements that are painful to perform ____Sitting ____Standing ____Walking
____Bending ____Lying down

Since your last visit have you had any of the following?
____ Accidents
____ Falls
____ New or changes in medication
____ Surgeries/broken bones
____ Change in job or activity level
____ Other medical conditions

Do your have any special concerns you would like to be addressed? _____

_____

_____