

New Patient Evaluation



What are you being seen for today? _____

When did this current episode begin? _____

Have you ever had this pain/problem before? _____

Was your chief complaint caused by an injury or following surgery? If so, please describe the injury or surgery:

Are your symptoms: Constant Intermittent

Are your symptoms: Better Worse Same

Do you have any numbness/tingling? Yes No

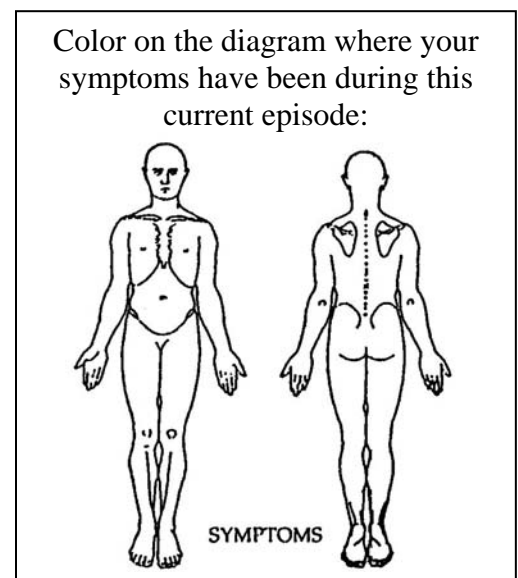
Pain on a Scale of 1-10 (10=worst): _____

Previous Related Injuries, Surgeries or Problems:

For this problem, have you had any special tests:

X-rays CT Scan MRI EMG

Other: _____



Have you tried any other treatment for this problem: (heat, cold, chiropractic) Did it help?

Do you have: Diabetes Pacemaker Cancer Other: _____

Do you have any allergies to: Latex Steroid Medicines Other: _____

What medications are you currently taking?

Females: Is there any chance you could be pregnant? Yes No

What job duties/positions at work flare up your symptoms?
