

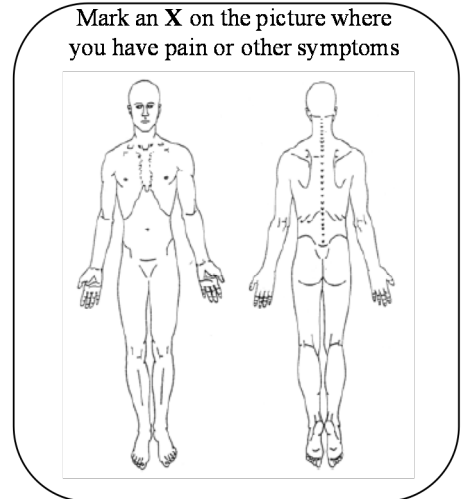
**INITIAL HEALTH STATUS**

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: M/F

Describe your current problem and how it began:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Date Problem Began: \_\_\_\_\_

Is this:  Work Related  Auto Related  N/A

How do you feel today? \_\_\_\_\_

No Pain **0 1 2 3 4 5 6 7 8 9 10** Excruciating  
 (please circle)

How often are your symptoms present?  0-25%  26-50%  51-75%  76-100%

Can you perform your daily activities?  Yes  No

In **No**, describe: \_\_\_\_\_

Have you had Spinal X-Rays, MRI or a CT Scan?  Yes  No Date(s): \_\_\_\_\_

What areas were taken?: \_\_\_\_\_

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

Please check all of the following that may apply to you:

<table border="0"> <tr> <td style="text-align: center;">Past</td> <td style="text-align: center;">Present</td> <td></td> <td style="text-align: center;">Past</td> <td style="text-align: center;">Present</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Numbness in Groin/Buttocks</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Visual Disturbances</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of Recent Infection</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Low/Mid Back Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High Blood Pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Frequent Urination</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Corticosteroid Use</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Prostate Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dizziness/Fainting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Epilepsy/Seizures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary Retention</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tobacco Use</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Birth Control Pills</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Alcohol Use</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Aortic Aneurysm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neck Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer/Tumor</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Arthritis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Osteoporosis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pregnancy, # 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I certify that the above information is complete and accurate. If the health status information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this therapist immediately whenever I have changes in my health condition or health plan coverage in the future.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_