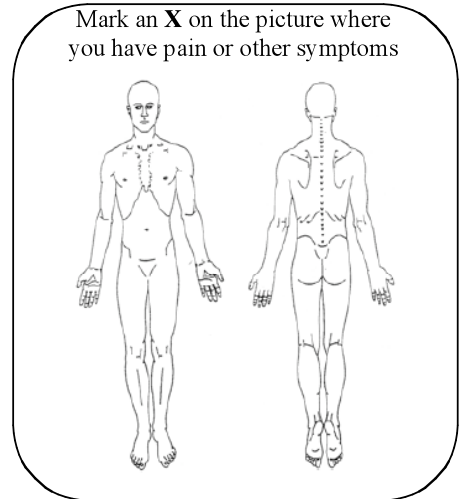


INITIAL HEALTH STATUS

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, # of births: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HIV/AIDS</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abnormal Weight: <input type="checkbox"/> Gain <input type="checkbox"/> Loss</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Surgeries (please list)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Trauma</td> <td colspan="3">_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fever</td> <td colspan="3">_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Stroke (date) _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Medications (please list)</td> </tr> <tr> <td colspan="6">_____</td> </tr> </table>	Past	Present		Past	Present		<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Low/Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	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: _____