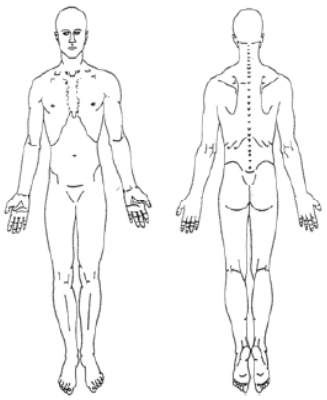
INITIAL HEALTH STATUS

Patient Name: Birthdate: Sex: M/F

Describe your current problem and how it began:

Mark an **X** on the picture where you have pain or other symptoms



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 you 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:

Past	Present		Past	Present	
☐	☐	Numbness in Groin/Buttocks	☐	☐	Visual Disturbances
☐	☐	History of Recent Infection	☐	☐	Low/Mid Back Pain
☐	☐	High Blood Pressure	☐	☐	Frequent Urination
☐	☐	Corticosteroid Use	☐	☐	Prostate Problems
☐	☐	Dizziness/Fainting	☐	☐	Epilepsy/Seizures
☐	☐	Urinary Retention	☐	☐	Tobacco Use
☐	☐	Birth Control Pills	☐	☐	Alcohol Use
☐	☐	Aortic Aneurysm	☐	☐	Neck Pain
☐	☐	Cancer/Tumor	☐	☐	Arthritis
☐	☐	Osteoporosis	☐	☐	Pregnancy, # of births:
☐	☐	HIV/AIDS	☐	☐	Abnormal Weight: ☐ Gain ☐ Loss
☐	☐	Diabetes	☐	☐	Surgeries (*please list*)
☐	☐	Trauma			
☐	☐	Fever			
☐	☐	Stroke (date)	☐	☐	Medications (*please list*)

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:**