



PATIENT BRIEF MEDICAL HISTORY AND INFORMATION

Federal and State Regulations require a medical history must be included in the patient's medical records in this office.

Reason for visit (area of pain): _____

How did this injury/exacerbation occur? _____

Have you been hospitalized for the present condition? Yes No If Yes, date: _____

Have you had surgery for the present condition? Yes No If Yes, date: _____

Are you currently receiving or have you received in the last 30 days any other home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize: _____

Have you had previous therapy for the present condition for which you are to receive treatment here?

Yes No If yes when and where did you have therapy? _____

Is this a work related injury or condition? Yes No

Have you ever had any of the following? If yes, please bring the report.

EMG CAT SCAN MYELOGRAM MRI XRAY

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply.**

Getting in/out of bed Shaving Cleaning Sleeping Lifting Writing Sitting Cooking

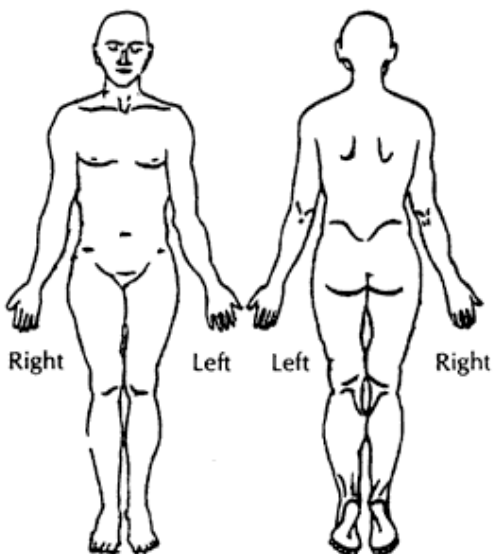
Getting in/out of a car Walking up/down stairs Dressing Standing Laundry Driving

Getting in/out of a chair Walking Vacuuming

On a scale of 0 to 10, (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worse _____

Please draw the symbol representing your pain over the area of the body as it relates to your present condition.



Signature _____ Date _____ / _____ / _____