Group/Policy #: _____

*Please bring a copy of all insurance cards to our office on your initial visit so that we may scan your card into our computer.

**In automobile or workman's compensation cases, please bring all contact information-insurance co, address, telephone/fax number, insurance adjuster's name and number, policy number.

***In auto injury cases, please bring copy of police report (and other person's information if they are at fault).

SYMPTOM INFORMATION (1 of 2)

Please fill out the following information so that we can have comprehensive data on your current condition.

Are your symptoms the result of an accident? Yes No

If yes, what type? Auto Job Other:_____

What date did your symptoms appear ?_____

Are your symptoms: Constant Frequent Intermittent Occasional

Where are you having symptoms:

Primary location _____

Secondary location _____

Additional location(s) _____

Are your symptoms radiating into your arms or legs? Yes No

Location: _____

Are your symptoms (circle all that apply):

Ache Burning Cramp Deep Dull Numbness Piercing Pins & Needles

Sharp Shooting Soreness Stabbing Spasm Tenderness Tightness

Tingling Throbbing Weakness

What **improves** your symptoms (circle all that apply):

Ice Heat Massage OTC Medication Muscle Relaxer/Pain Med Rest Physical

Activity Bending Sitting Standing Walking

Other_____

SYMPTOM INFORMATION (2 of 2)

What **aggravates** your symptoms (circle all that apply):

Bending Coughing Driving Lifting Movement Physical Activity Rest

Sitting Sneezing Standing Twisting Walking

Other_____

Do symptoms affect (circle all that apply):

Sleep Daily Activities Work Activities Recreational Activities

Describe your job activities: _____

Please rate your pain from 0 (no pain) to 10 (unbearable pain) for:

Primary Symptoms_____ ; Secondary Symptoms_____ ; Third Symptoms_____;