Name _____ Phone_____ DOB_____

Address_____ City/State/Zip_____

Email_____ Primary Physician _____

Emergency Contact_____ Relationship_____ Phone_____

How did you hear about us? _____

Medical History

Have you recently experienced any of the following? (Please check ALL that apply)

□ Changes in appetite □ Difficulty swallowing
□ Changes in bowel or bladder function
□ Fever/chills/sweats □ Headaches
□ Difficulty maintaining balance while walking
□ Dizziness/lightheadedness □ Nausea/vomiting
□ _____

Have you ever been diagnosed with any of the following conditions? (Please check ALL that apply)

□ Alzheimer's disease/dementia
□ Lung problems
□ Asthma
□ Multiple sclerosis
□ Cancer (if yes, type: _____)
□ Osteoporosis
□ Depression
□ Pacemaker inserted
□ Epilepsy/seizures
□ Parkinson's disease
□ Heart disease (if yes, type:_____)
□ Rheumatoid arthritis
□ High blood pressure
□ Stroke
□ Kidney/liver problems

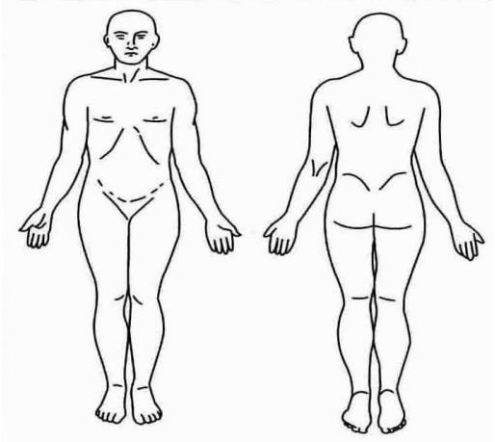
Describe your main concerns in order of priority (symptoms, onset, diagnoses, duration etc.)

1._____

2._____

Pain Assessment:

Please mark location/type of pain here



X: Sharp, stabbing pain

O: Dull, achy pain

///: Numbness/tingling

==: Burning

Pain Scale: 0=None 5=Moderate 10=Extreme

At worst: 0 1 2 3 4 5 6 7 8 9 10
Current: 0 1 2 3 4 5 6 7 8 9 10
At best: 0 1 2 3 4 5 6 7 8 9 10

Aggravating Factors:

□ Sitting □ Standing □ Walking □ Lying down/Sleeping □ Stairs □ Reaching
□ Lifting □ Getting up from a chair □ Bending forward
□ Carrying heavy objects

Medications: please list them below

_____

_____

THANK YOU! WE ARE EXCITED TO GET STARTED!