Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions.

Direction of Feed

New Patient / Return Patient New Problem

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****.*
Fold only on the dotted lines.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

INJURY / CONDITION

Was this the result of an injury? ◯ yes ◯ no **Date of injury:** _____

If yes, where did it happen? ◯ home ◯ school ◯ auto ◯ work ◯ public **other:** _____

Are you claiming as Workers' Compensation? ◯ yes ◯ no

TYPE OF PROBLEM

◯ pain ◯ weakness ◯ swelling **other:**
◯ sprain / strain ◯ fracture ◯ numbness / tingling _____

LOCATION OF YOUR INJURY / CONDITION

please fold on dotted line

	RIGHT	LEFT	BOTH SIDES
collar bone	◯	◯	◯
shoulder	◯	◯	◯
arm	◯	◯	◯
elbow	◯	◯	◯
wrist	◯	◯	◯
hand	◯	◯	◯
fingers	◯	◯	◯
pelvis	◯	◯	◯

	RIGHT	LEFT	BOTH SIDES
hip	◯	◯	◯
leg	◯	◯	◯
knee	◯	◯	◯
ankle	◯	◯	◯
foot	◯	◯	◯
toes	◯	◯	◯
back pain	◯	◯	◯
neck pain	◯	◯	◯

other: _____

PREVIOUS TREATMENT

Have you been seen by any other doctor for this injury / condition? ◯ yes ◯ no

If yes, what type? ◯ Orthopaedic Doctor ◯ Chiropractor ◯ Family Doctor / Primary Care Physician ◯ Occupational Medicine **other:** _____

When did you see the other physician? ◯ within the last month ◯ greater than 6 months ◯ less than 6 months ◯ 1 or more years

Have you had any of the following for this problem? ◯ **NONE** ◯ MRI ◯ Bone Scan ◯ X-ray ◯ CT ◯ EMG / NCS (Electromyography / Nerve Conduction Study)

other: _____

please fold on dotted line

Have you received any of the following treatments for this problem? (Mark all that apply. If none, mark "**NONE**".)

◯ Injection	**If yes, did it help?**	◯ yes	◯ no
◯ Medications	**If yes, did it help?**	◯ yes	◯ no
◯ Physical Therapy	**If yes, did it help?**	◯ yes	◯ no
◯ Surgery	**If yes, did it help?**	◯ yes	◯ no
◯ **NONE**			

TOBACCO USE

Please describe your cigarette smoking status: ◯ never smoked ◯ former smoker ◯ current smoker (every day) ◯ current smoker (some days)

If you smoke, how many packs per day? ◯ <½ ◯ ½ ◯ 1 ◯ 1½ ◯ 2 ◯ >2

Do you use any smokeless tobacco products? ◯ chewing tobacco (dip) ◯ snuff ◯ vapor (e-cigarettes)