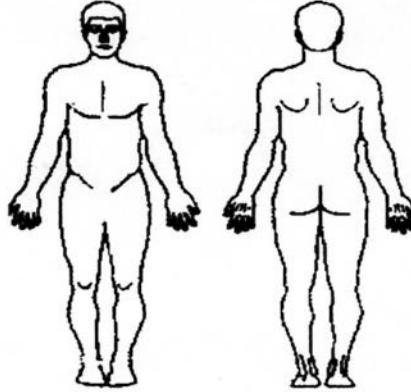


INITIAL HEALTH STATUS

Patient Name _____ Birthdate _____ Sex: M / F

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



Current Complaint (How do you feel today)

0 1 2 3 4 5 6 7 8 9 10

No Pain

Unbearable Pain

How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100%

Can you perform your daily activities Yes No (Describe) _____

Have you had spinal X-Rays, MRI or CT Scan? Yes No Date(s) Taken _____

What areas were taken? _____

Are you pregnant or is there a possibility that you may be pregnant? Yes No Possible

Please check all of the following that apply to you:

If none apply check here

YES	NO	Condition	YES	NO	Condition
<input type="checkbox"/>	<input type="checkbox"/>	History of recent infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # of births _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	History of Low / Mid Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date) _____	<input type="checkbox"/>	<input type="checkbox"/>	History of Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin / Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Cancer / Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Recent Trauma
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries / Medications: _____			

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems / Stroke

I certify that the above information is complete and accurate. If the health plan 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 doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature _____ Date _____