Please complete this form in detail on this page and on the backside.

PERSONAL INFORMATION:

Name: _____ Spouse's Name: _____

Please circle one: *Dr.* *Mr.* *Mrs.* *Ms.* *Miss* Number of children: _____

Street Address: _____

City: _____ Postal Code: _____

Cell phone number: _____ Landline phone number: _____

Email: _____

Occupation: _____

Date of Birth: _____day _____month _____year Age: _____

Have you ever been hospitalized? ____yes ____no

Have you had recent x-rays? ____yes ____no

Weight: _____ Family history of diabetes: _____yes _____no

Medical physician's name: _____ List medications: _____

(Continue in space below if needed)

Referred by: _____

Is this consultation a result of a: Motor vehicle accident: _____yes _____no
Workplace injury: _____yes _____no

Make a checkmark in the circle of all symptoms that apply to you:

Condition	***Happening currently…***	***Happened in the past…***
Neck pain or stiffness	O	O
Pins/needles sensation in arms	O	O
Numbness in fingers	O	O
Headaches	O	O
Low back pain	O	O
Pins/needles sensation in legs	O	O
Numbness in legs/toes	O	O
TURN PAGE OVER…		

Condition	***Happening currently…***	***Happened in the past…***
Weakness in legs	O	O
Arthritis	O	O
Weight change	O	O
Night sweats	O	O
Low energy	O	O
Fainting	O	O
Vision trouble	O	O
Difficulty with speech	O	O
Memory loss	O	O
Ringing in ears	O	O
Loss of balance	O	O
Chest pain	O	O
Heart condition	O	O
Cardiovascular disease	O	O
Decreased appetite	O	O
Frequent urination	O	O
Constant thirst	O	O
Anxiety	O	O
Depression	O	O
Mood swings	O	O
Menstrual pain	O	O

Mark the areas on the body where you are feeling the sensation or pain using the symbols below:

Aching pain: (((((

Burning pain: XXX

Numbness: ===

Pins and Needles: 0000

Stabbing pain: ////