

Payment is due at time of service.

THIS SIDE PHYSICIAN USE ONLY

PATIENT'S NAME: _____ Date: ___/___/2008

AGE: _____ SS#: _____--____--____ (Required for Insurance)

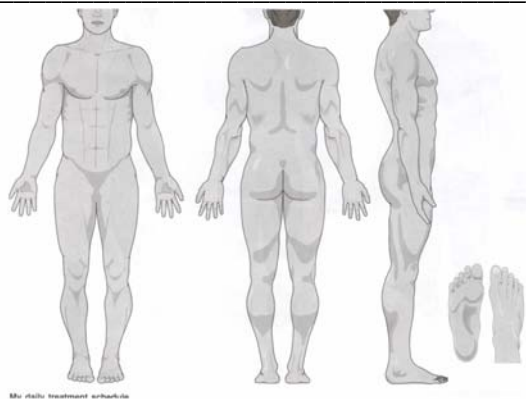
PLEASE CHECK THE APPROPRIATE BOX BELOW (1 BOX MUST BE CHECKED)

Worker's Comp No-Fault MVP Private Medicare

Date of Injuries: _____ Date of Surgery: _____

HOW ARE YOU FEELING? (Please be specific) _____

HT: _____ WT: _____



Please rate your pain 1-10
(0 = no pain, 10 = extremely severe pain)

Neck /10
Right Arm /10
Left Arm /10
Back /10
Right Leg /10
Left Leg /10

Do you have Good Control of your Bowel & Bladder?

What are your Medication **ALLERGIES**?

Females- Is there a chance you may be Pregnant?

Please list **ALL MEDICATIONS** you are taking (If you need more space please use back of sheet)

HOW ARE YOUR THERAPIES HELPING?

Physical therapy

Elliptical Cross-Training

Walking

Treadmill

Swimming

Strength Training

Biking

Chiropractic Care

Using a Brace

Interferential/Sequential stimulation

Pain Management

Bone Stimulator

What can we do to further help your Neck/Back & Issues to discuss:

Primary Physician: _____

Address: _____

C1 C2 E1 E2

EXAM

Runner Present: _____

REFLEXES	R	L
Biceps	/2	/2
Brachioradialis	/2	/2
Triceps	/2	/2
Knee	/2	/2
Ankle	/2	/2

SENS	R	L
C5		
C6		
C7		
C8		
T1		
L2		
L3		
L4		
L5		
S1		

MP	R	L
C5	/5	/5
C6	/5	/5
C7	/5	/5
C8	/5	/5
T1	/5	/5
L2	/5	/5
L3	/5	/5
L4	/5	/5
L5	/5	/5
S1	/5	/5

HOMAN'S : Negative/ Positive

None

IMAGING: All

Comprehensive

New

Old

PATIENT WAS GIVEN:

STUDIES _____

RX SAMPLES _____

PNT received

PNT recommended

Consents signed

HNP

DDD

SS

Spondylolisthesis

Scoliosis