

PLEASE ANSWER ALL OF THE FOLLOWING:

Briefly describe your injury: _____

Have you had surgery? Yes No If yes, when? _____

Are you taking medication for:

Pain Diabetes Blood Pressure Cholesterol
 Heart Thyroid Vertigo Blood Thinner

Other: _____

On the scale below circle your worst pain level in the past week:

Mild 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10 Severe

Have you ever experienced heart problems, including heart surgery? Yes No

Do you have a pacemaker? Yes No

Have you ever tested positive for tuberculosis? Yes No

Do you have diabetes? Yes No

Do you have a history of seizures? Yes No

Do you have a history of dizziness? Yes No

Do you have a history of hypertension? Yes No

Do you have any joint or muscle problems or injuries? Yes No

Do you have neck problems including neck surgery? Yes No

What are your hobbies/sports? _____

Are you able to perform them at this point? Yes No

If employed, are you working at this time? Not employed

If yes: Light Duty Modified Duty Regular Duty

Were you seen by a physical therapist or a chiropractor regarding this injury before your doctor referred you to us? Yes No

If yes, how many weeks were you treated? _____

Signature

Date