NEW PATIENT INFORMATION

CHART #:_______________

ORDERING PHYSICIAN:____DATE:_______________

PATIENT NAME: ________________________________SEX____D.O.B.__________AGE_________

ADDRESS: ____SSN: ______-______-__________

CITY____________STATE_____________ZIP____________PHONE__________________________

MARITAL STATUS: (circle one)   SINGLE   MARRIED   DIVORCED   WIDOWED

EMPLOYER_________________________________ PHONE_________________________________
JOB TITLE__________________________________ DATE LAST WORKED__________________
SPOUSE'S NAME____________________________ SPOUSE'S EMPLOYER_________________
EMERGENCY CONTACT____________________ PHONE_________________________________

IN ORDER TO PROVIDE THE BEST RESULTS, THE DOCTOR NEEDS TO KNOW ABOUT YOUR PAIN.

CHECK ONE: AUTO ACCIDENT_______ WORK RELATED INJURY______ OTHER________

DATE OF ACCIDENT OR INJURY: _____________

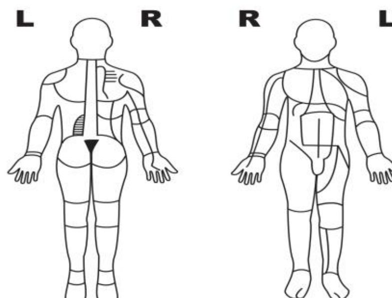
PLEASE CHECK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

HEADACHES: YES ____ NO ____ FREQUENCY________ SEVERITY__________

RADICULOPATHY: YES ____ NO ____ (numbness/pain from the shoulder-fingers or hips-feet)
RIGHT ARM____ LEFT ARM____ RIGHT LEG____ LEFT LEG____

INDICATE WHERE YOUR PAIN IS LOCATED BY MARKING AREA ON THE DIAGRAM.

HEIGHT_________ **WEIGHT**_________



_________________________________ _________________________________
Patient Signature Date Technologist Signature Date

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