

# IMPORTANT

Our patient forms must be **downloaded** and **SAVED** to your computer **before** you begin to fill them out.

## ADOBE ACROBAT READER

[click link below to download for free]

<https://get.adobe.com/reader/otherversions/>

is required for your information to be saved properly on each form.

Be sure to **SAVE** your completed forms to your computer before uploading the files to us.



# Existing Patient | New Injury Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is your injury due to a car accident or work related injury?  Yes  No

If yes, Date of Injury \_\_\_\_\_ Do you have an attorney for your injury?  Yes  No

Has this been reported to your employer?  Yes  No Are you still working?  Yes  No

**If YES to the above questions, please STOP and contact the FRONT OFFICE!**

Is this due to a non-work related injury?  Yes  No

If yes, when? \_\_\_\_\_ where? \_\_\_\_\_ what time? \_\_\_\_\_

Problem being seen for today: \_\_\_\_\_  Right  Left

What symptoms are you experiencing? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you experienced this problem in the past?  Yes  No If yes, please describe: \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Have seen another physician for this problem?  Yes  No Please explain: \_\_\_\_\_

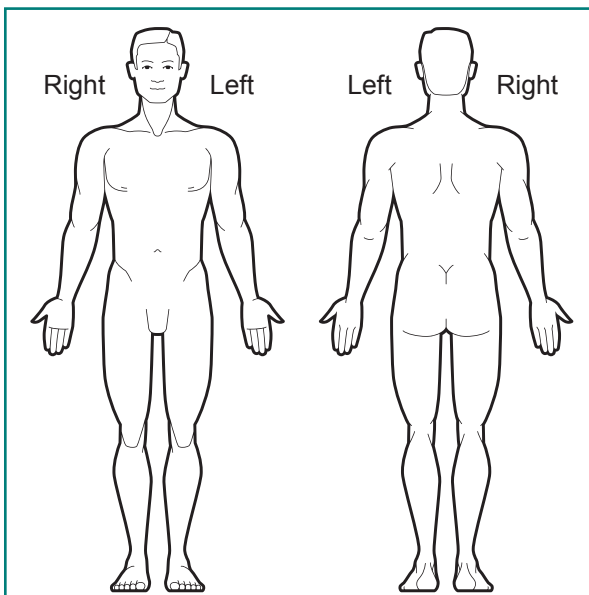
Have you had prior treatment for this problem?  Yes  No Please explain: \_\_\_\_\_

Had any prior testing? (Please check)  X-rays  MRI  CT Scan  EMG  DEXA (Bone scan)

If yes, Where? \_\_\_\_\_ When? \_\_\_\_\_

**On the illustration below, please use the following symbols to explain your symptoms:**

Aching ^^^^ Sharp <<<< Burning //// Dull Ache ==== Numbness x x x x Pins/Needles \* \* \* \*



**Pain Scale (Please Check)**

- 0 No pain
- 1
- 2
- 3
- 4
- 5 Moderate Pain
- 6
- 7
- 8
- 9
- 10 Severe Pain

Height \_\_\_\_\_ Weight \_\_\_\_\_

