Name _____ DOB _____ Date _____ Allergies _____

Please describe your problem: _____

In what way is your problem limiting you?_____

What movements or activities make it worse?_____

What movements or activities make it better?_____

What medications and/or therapies have you tried?_____

Please list any imaging and/or procedures you have had for this problem:_____

Please describe any traumatic injuries you have sustained in your life, including motor vehicle accidents, falls, concussions and broken bones:_____

Name _____ DOB _____ Date _____ Allergies _____

Medical History (including current and chronic illnesses, hospitalizations):_____

Surgical History (including dates):_____

Current Medications (including supplements, herbals, homeopathic):_____

Family History (parents, siblings and children):_____

Do you smoke, if so, what and how many per day? _____

Do you drink alcoholic beverages, if so, how many per week? _____

Please describe your exercise routine:_____

How would you describe your diet?_____

Physicians (including PCP):_____

Name _____ DOB_____ Date_____

Please use the diagram below to draw in where you have pain or problems.