Back In Action Health Resource Center

Name:(F)_____(M)_____(L)_____
Address:_____City:_____
State:_____Zip:_____Email:_____
Primary Phone Number:_____(home / cell / work)
Secondary Phone Number:_____(home / cell / work)
Date of Birth:____/_____/_____SS#_____Marital status:_____
Employer:_____Occupation:_____
Primary Care Physician:_____Insurance Carrier:_____
Date of last physical exam and any results of concern:_____
How did you hear about our office?_____
Do you know today's winning lottery number? Y/N (please print clearly)_____
How would you rate your overall health? __Excellent __Good __Poor
Why are you here and what do you hope to gain from your experience?

_____

_____

Please draw on the diagram below, indicating any areas of pain or problems, using the following letters to indicate specific descriptions:

A=Ache B=Burning N=Numbness/Tingling S=Sharp/Stabbing T=Tight W=Weakness O=Other
Next to all problem areas, also indicate your level of pain on a 1-10 scale: 0=none/ 10=unbearable