

**ABOUT YOU:**

Today's Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

How would you like to be addressed by our staff? \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Daytime Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Your primary care (medical physician) is: \_\_\_\_\_

Phone # (physician) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ May we send a report to him/her about your examination and treatment?  Yes  No

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Hand Dominance:  Right  Left  Ambidextrous

What is your complaint? \_\_\_\_\_

Is your complaint related to a car accident or work injury?  Yes  No If yes, date of injury? \_\_\_\_\_

**PLEASE CHECK EITHER YES OR NO IN THE SPACES PROVIDED BELOW**

Surgeries:  None  Yes - *Please list on blank spaces below with approximate year (if known)*

Surgery	Year Performed	Surgery	Year Performed
<i>Example: Gall bladder removed</i>	1992		

Previous Illness or Diseases (i.e. Cancer):  None  Yes *Please list with approximate year of diagnosis:*

Disease/Disorder	Year Diagnosed	Disease/Disorder	Year Diagnosed
<i>Example: Diabetes</i>	1992		

Past/Present Injuries:  None  Yes *Please describe with approximate date* (may include injury for which you are here today)

Injury	Approx. Date	Injury	Approx. Date
<i>Example: Car Accident</i>	1980		

List below any FRACTURES, along with the date/year of the injury:  None  Yes

INJURY	DATE	INJURY	DATE

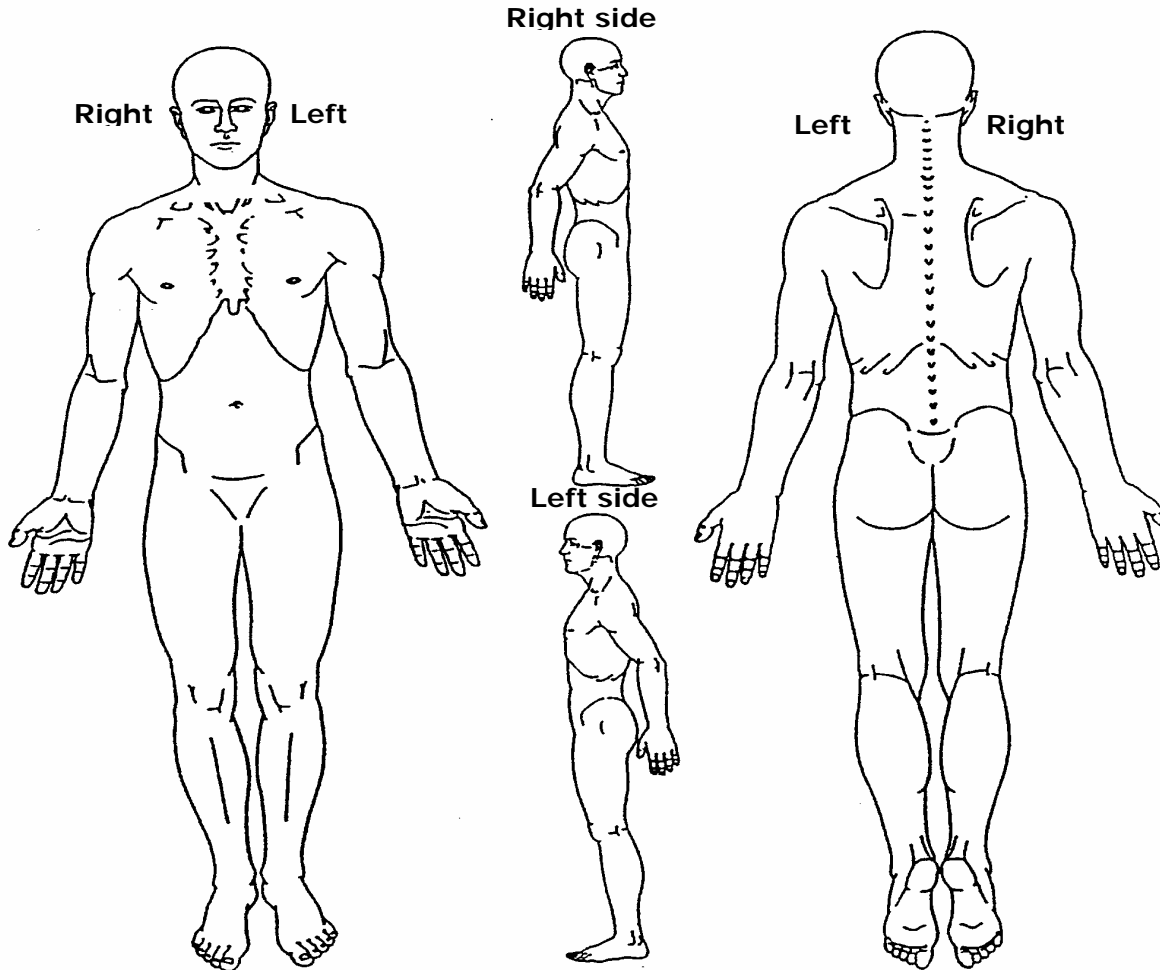


PATIENT NAME \_\_\_\_\_

**Instructions:** Use the symbols in the “key” below to indicate the type and location of the discomfort AS IT FEELS TODAY. Place the letters on the part of the body that you feel the discomfort.

**KEY**

<b>A = ACHE</b>	<b>B = BURNING</b>	<b>C = STABBING</b>
<b>N = NUMBING</b>	<b>P = PINS &amp; NEEDLES</b>	<b>O = OTHER</b>
<b>S = SORE</b>	<b>T = TIGHT</b>	<b>ST = STIFF</b>

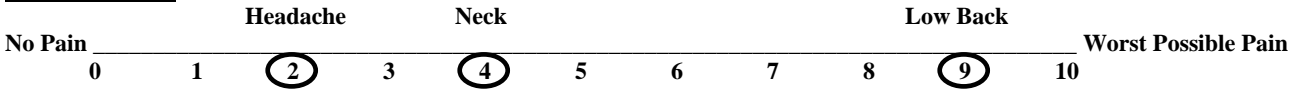


Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

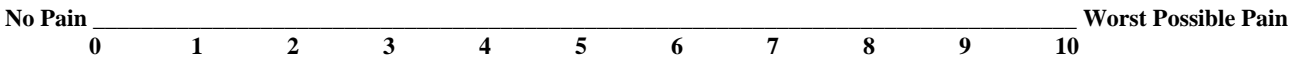
**INSTRUCTIONS:** Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst.

**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

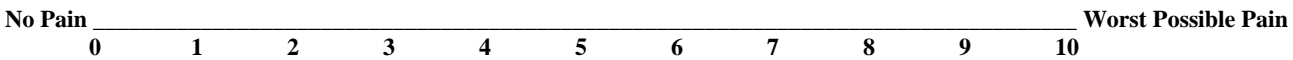
**EXAMPLE:**



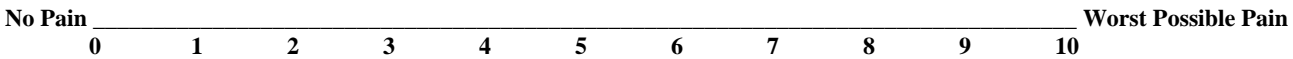
**1 – What is your pain RIGHT NOW?**



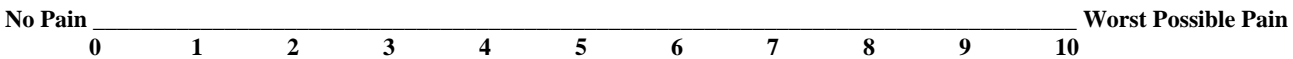
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best?)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst?)?**



**OTHER COMMENTS:**

**Patient signature**

**Date**

Examiner Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

As required by the Federal Privacy Regulations, I hereby acknowledge that I have received a current copy of **Russeau Team HealthCare, Ltd.'s "NOTICE OF PRIVACY PRACTICES,"** revision date MAY 17, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

***(OFFICE USE ONLY)***

Signed form received by: \_\_\_\_\_ Date: \_\_\_\_\_

Good faith effort to obtain receipt: (Describe) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_