PATIENT HISTORY- Update

Please complete this entire form. This confidential information will be part of your permanent records. THANK YOU.

Name _____ Date_____

If there has been a change in your address, please update below:

Address _____ City _____ State _____ Zip _____

Please describe in your own words the symptom(s) you are experiencing:

_____

_____

_____

_____

How long have you had this symptom(s)? _____

_____

Have you had this or a similar symptom(s) in the past? _____

_____

Are there any positions that make it feel worse? _____

Are there any positions make it feel better? _____

Is this condition interfering with your: □ Work □□ Sleep □□ Daily Routine Other _____

_____

Has any other doctor or therapist treated THIS condition: _____

_____

What do you think caused this condition? _____

_____

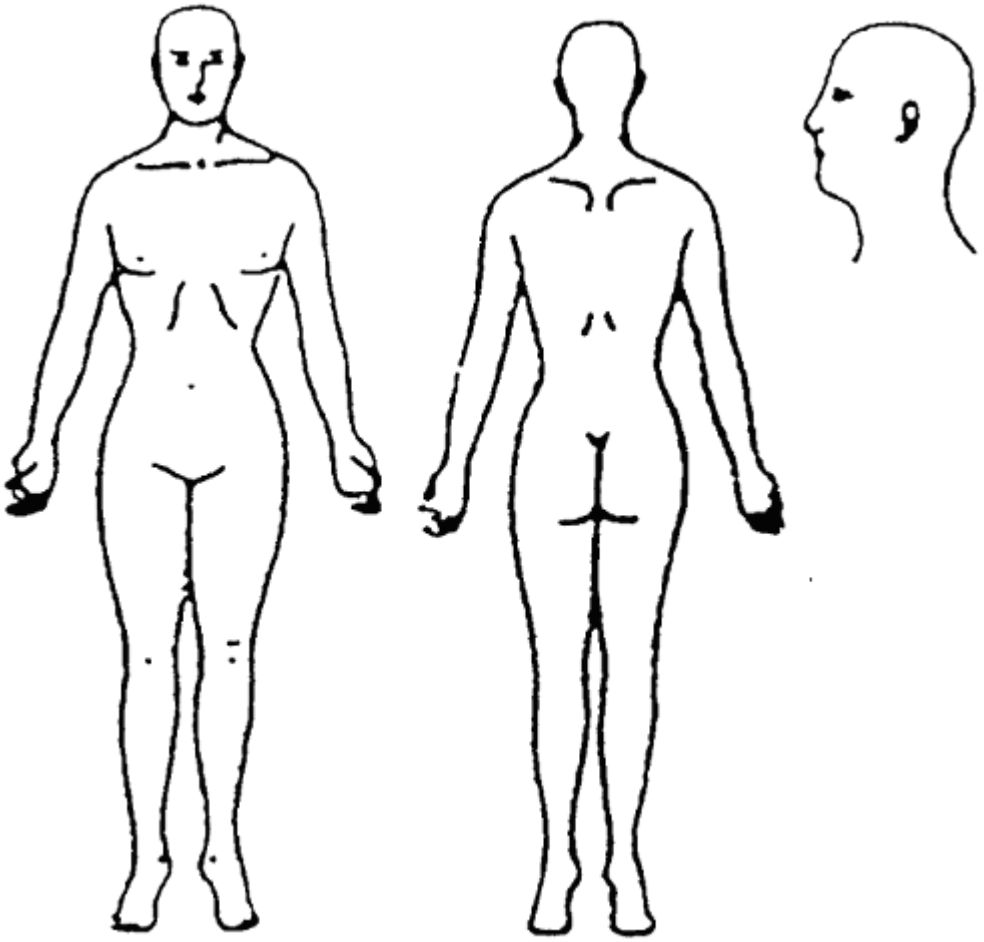
Signature _____ Date _____

Parent/Guardian _____Date _____

Name _____ Date _____

Please fill out this form as accurately as possible. Mark the area(s) on the body diagram where you feel your described symptom(s). Use the appropriate symbol(s) to mark areas of the body. Include all affected areas.

Aches = **o** Numbness = ▲ Pins/Needles = □ Burning Sensation = **x** Stabbing Sensation = ↑



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None ——————————————— Severe

How bad have your symptoms been in the past?

None ——————————————— Severe