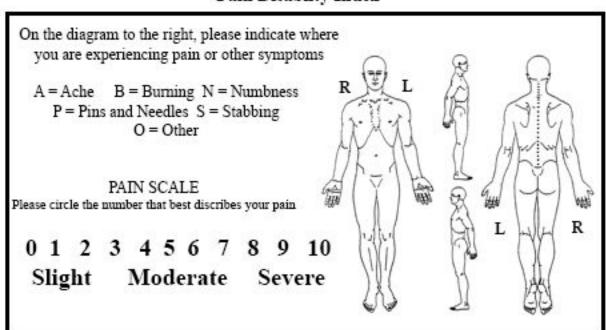


Patient Information

Name:					SS#:
Birthday:	Age:	Sex:	M	F	Marital Status: S M O
Phone:	Home /Cell E	nail:			00
Address:	City:				State: Zip:
Employer:	Occupation:		27832		Work Phone:
Purpose of visit:	stania Sii				
Where is your pain?		W	hen d	lid i	it start?
What were you doing when y	ou first noticed it?				
When do you feel it most? A	M PM Standing	Sitti	ng '	Wal	king Lying Down
What does it feel like? Sharp	마이나 한 사람이 있다면 하는 사람이 없어 없었다.		- T		AND AND THE STANFORD AND THE STANFORD AND AND AND AND AND AND AND AND AND AN
Was this caused by an accider	nt? Yes No		Ĩ.		20 A
If yes, what kind of a	cident? Auto	Work	H	ome	e Other
Date of accident:	I	lave y	ou n	nade	e a report? Yes No
Have you seen a chiropractor	before? Yes No				
How did you hear about us?		8			
275 AH					

Pain Disablity Index





Do you suffer from a	my of the following conditions	(please circle all that apply)				
Allergies Arthritis Asthma Arm/Shoulder Pain Blurred Vision Carpal Tunnel Diabetes Difficulty Sleeping Dizziness	Digestive Problems Depression Ears Ringing Fatigue Foot/Toe Numbness Gout Hand/Finger Numbness Headaches Heartburn/Acid Reflux	Jaw Pain Low Back Pain Leg Pain Mid Back Pain Neck Pain Tension				
If yes, who? MD Name	ealth care professional for you DO DC PT Other Treatment falls, auto accidents, fractures	Did it help? Yes No				
List any current medication	ns you are taking					
Who is your chiropractor? What did you go there for? Why did you stop care?	·	Did it help? Y N				
DAVAGENT	IC EVDECTED AT TIM	TE OF SERVICE				
Who is responsible for thi Relationship to patient: S Insurance Company: Please print your name: _ Signature of patient, parer The above signed consent	elf Spouse Parent Guard Policy # nt, guardian: s to treatment by the chiroprace	dian Other				
Merrill, DC at Pahoa Chiropractic. Date:						