

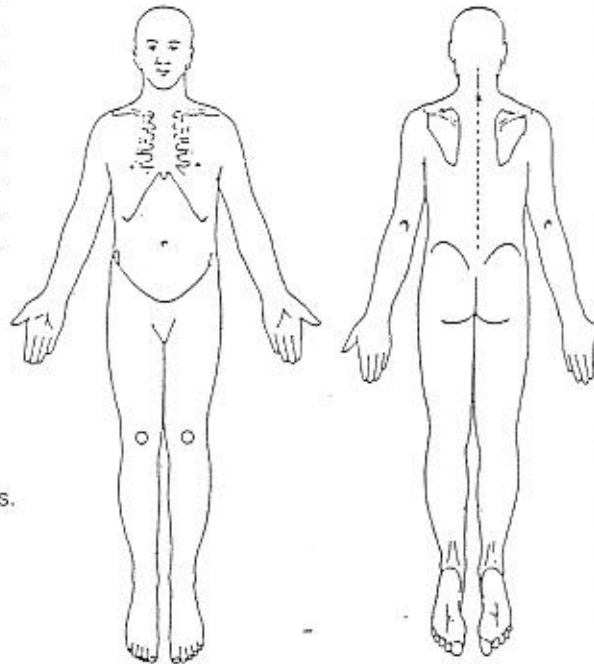


**Personal Data**

1. Are you currently working?  yes  no  
 2. If yes, please give your occupation and describe physical demands. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Complaint**

1. What is your main complaint or problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



2. It is important that we have a measure of your pain. Please rate the level of your pain on a scale of 1 to 10.  
 1 2 3 4 5 6 7 8 9 10  
 Mild Moderate Extreme  
 discomfort pain agony

3. Please indicate painful areas by shading these models.

4. Which of these words describe your pain?  
 (Check all that apply.)  
 Sharp  Dull  Burning  Aching  
 Tingling  Numb  Constant  
 Variable  Radiating (moves)

5. Are there any positions or activities that make your pain worse? \_\_\_\_\_  
 \_\_\_\_\_  
 6. Are there any positions or activities that lessen your pain? \_\_\_\_\_  
 \_\_\_\_\_

**History**

How did your problem start? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What tests or treatment have you had for this problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any/all medications you are currently taking: \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

List any surgeries: \_\_\_\_\_

Other Medical Conditions \_\_\_\_\_

Are you aware of your Diagnosis? YES \_\_\_ NO \_\_\_ Are you aware of your Prognosis? YES \_\_\_ NO \_\_\_

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to The Back Clinic, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.  
 Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_