Date: _____
File: _____

PERSONAL INFORMATION

Name: _____ _____ _____
(Last Name) (First Name) (Middle Name)

Health Number: _____ **Date of Birth:** _____
(dd / mm / year)

Place of Birth: _____

Address: _____
(Street Name) (City) (Prov) (Postal Code)

Phone Number: _____
(Home #) (Business #) (Cell #)

Occupation: _____

Marital Status: ☐Single ☐ Married ☐Widowed ☐Divorced ☐Separated **Number of Children:** _____

Emergency Contact: _____
(Name) (Contact #)

How did you hear about the clinic? (Please specify) _____

PRESENTING COMPLAINT

What is your reason for consulting this office? _____

How long have you had this condition? _____

What seems to help this problem? ☐ Heat ☐ Ice ☐ Other _____ ☐ Nothing

What seems to make the problem worse? _____

Is this condition getting: ☐ Better ☐ Worse ☐Constant ☐ Comes and goes ☐ Other _____

Describe any previous treatments sought for this problem: _____

Please list any other problems or concerns you would like to discuss with the practitioner:

_____

PAIN DIAGRAM

On the diagrams below, please circle the areas of concern and indicate the quality of pain you are experiencing.
(Sharp, dull, ache, stab, burn, shooting, numb, throb, tingle, etc.)