PATIENT CONDITION FORM mm wc mvc pi med t19 cash Patient#

Name: ______________________ Birth Date __________ Gender: ☐ Male ☐ Female

Address: ______________________ Social Security # __________

City: __________ State: ______ Zip: __________ Email __________

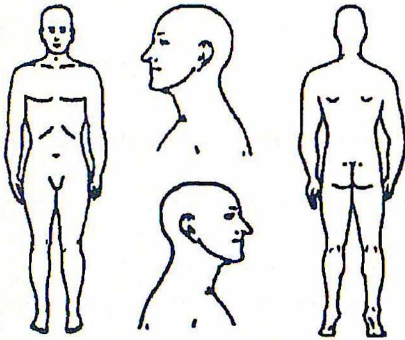
Home phone __________ Cell phone __________ Work phone __________

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired Occupation: __________

Place of employment: __________ Marital Status: _M__S__W__D Name of Spouse/Parent __________

Primary Insurance __________ Secondary __________

Who referred you to our office? __________ Relationship? __________



Describe MAJOR complaint? ______________________

Any other complaints? ______________________

Date problem began? __________ It came on ☐Suddenly ☐ Gradually

How did this problem begin (falling, lifting, etc)? __________

(Please mark complaints on body)

Have you had this condition in the past? YES - NO

Have you received treatment for this? YES - NO If so by whom? __________

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:

☐ Burning ☐ Dull ☐ Numb ☐ Radiating Pain ☐ Sharp ☐ Shooting

☐ Stabbing ☐ Tightness ☐ Tingling ☐ Throbbing ☐ Other: __________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 0☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? __________

What makes your pain better (ice, heat, massage, etc)? __________

If Female, are you pregnant? Yes – No How many weeks? _____

Do you have a Pacemaker? Yes – No

If you have been a patient here before, has there been any surgery, trauma, illness, or change in medications since your last visit? __________

Patient's signature (or guardian) ______________________ ***Date*** __________