NEW PATIENT INFORMATION

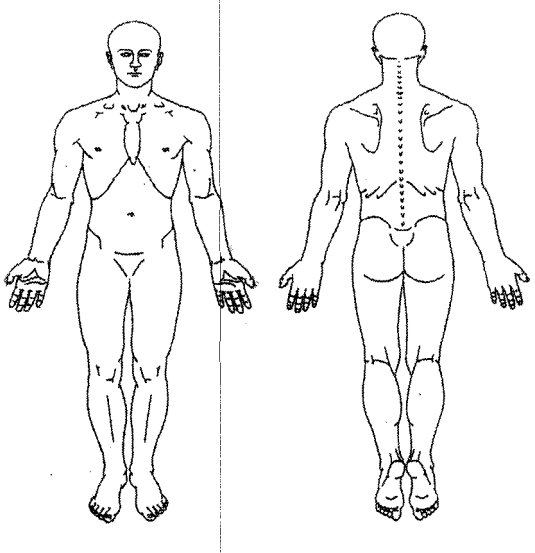
NAME: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

REFERRER: _____ PRIMARY DOCTOR: _____ OCCUPATION: _____

Is this a work-related injury? ▫ Yes ▫ No Is this an auto-accident-related injury? ▫ Yes ▫ No
Date of Injury:____/____/____ Date of Injury:____/____/____

Please mark the area(s) of the body where your pain is on the diagram below with the following identifier(s):

N = Numbness **T** = Tingling **D** = Dullness
S = Sharp **B** = Burning **A** = Aches



Where is the pain? _____

When did the pain initiated? _____

How did the pain initiated? _____

Is the pain intermittent or constant? _____

What makes your condition **worse**? (sitting, standing, walking, lying, typing, etc) _____

What makes your condition **better**? (sitting, standing, walking, lying, typing, etc) _____

Have you had an **XRAY and/or MRI**? If yes, when and where?
_____

What **treatments** have you tried to date?
(PT, exercise, AP, chiropractor, massage, injection, surgery, etc)
_____

Current medication(s): _____
Drug Allergy: _____

How bad is the pain currently? NO PAIN 1 2 3 4 5 6 7 8 9 10 MISERABLE

What would you like to accomplish with Dr. Chen today? (PT, exercise, AP, chiropractor, massage, injection, surgery, etc) _____

Medical Condition(s): (Diabetes, high blood pressure, cholesterol, disease, cancer, HIV, etc)
_____

Surgery: (Appendectomy, Back Surgery, Shoulder surgery, Gall bladder surgery, Heart surgery, etc)
_____

Family Medical Condition(s): (Diabetes, high blood pressure, cholesterol, disease, cancer, HIV, etc)
_____

Social History: (Alcohol usage, Smoking, Illegal Drugs, etc) _____

Constitutional Symptoms			Explanation
Fever	▫ Yes	▫ No	_____
Weight Loss	▫ Yes	▫ No	_____
Other	▫ Yes	▫ No	_____
Eyes			
Loss of vision, blurred vision	▫ Yes	▫ No	_____
Respiratory			
Lungs/breathing	▫ Yes	▫ No	_____
Chronic bronchitis	▫ Yes	▫ No	_____
Gastrointestinal			
Stomach/intestines	▫ Yes	▫ No	_____
Genitourinary			
Genitals/kidney/bladder	▫ Yes	▫ No	_____
Hematologic			
Blood	▫ Yes	▫ No	_____
Lymph nodes	▫ Yes	▫ No	_____

Allergic/Immunologic			Explanation
Head allergy symptoms	▫ Yes	▫ No	_____
Seasonal/Hay fever	▫ Yes	▫ No	_____
Ears, nose, mouth, throat			
Sinus congestion	▫ Yes	▫ No	_____
Runny nose	▫ Yes	▫ No	_____
Post-nasal drip	▫ Yes	▫ No	_____
Musculoskeletal			
Muscle/Joint	▫ Yes	▫ No	_____
Integumentary			
Skin, breast	▫ Yes	▫ No	_____
Neurological	▫ Yes	▫ No	_____
Psychiatric	▫ Yes	▫ No	_____
Endocrine	▫ Yes	▫ No	_____
Cardiovascular			
Heart/Blood vessels	▫ Yes	▫ No	_____

PATIENT'S SIGNATURE _____ DATE: _____