Name:_____ Date:_____

Address: _____

Phone Number: _____ Email: _____

Insurance Company: _____ ID #: _____

Return Patient History Form:

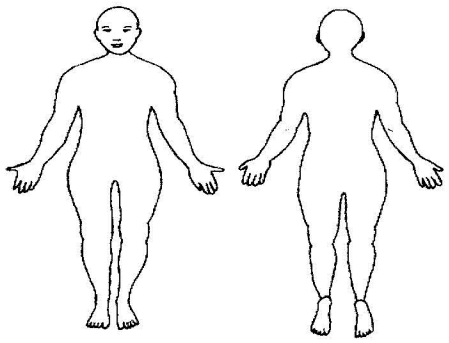
1. Reason for your visit:_____
2. When did your symptoms begin?_____
3. Is this a flare up of your previous complaint?_____
4. Did you have an accident (specify if motor vehicle or work related) that caused this most recent incident?_____

Please review your initial intake form. Then complete the following:

5. Mark on the diagram where you are having your current complaint:

6. **Type of pain:**

__ Sharp __ Dull __Throbbing __Numbness __Aching __Shooting
__Burning __Tingling __Cramping __Stiffness __Swelling __Other



7. Any injuries, illnesses, or changes in health since your last visit?_____

_____

8. Any changes in medications since your last treatment?_____

_____

9. Any changes in nutritional supplements since your last treatment? _____

_____