Dr. Deanna Leigh DC
*mutzel*

# CHIROPRACTIC REGISTRATION & HISTORY

## PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name

_____
Last Name

_____ _____
First Name Middle Initial

_____
Address

_____
City

_____
State Zip

_____
Email
Sex ☐ M ☐ F Age _____
Birthdate _____
☐ Married ☐ Widowed
☐ Single ☐ Minor
☐ Separated ☐ Divorced
☐ Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____

_____
Employer/School Phone ( _____ ) _____

Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

_____

## PHONE NUMBERS

Cell Phone ( _____ ) _____
Home Phone ( _____ ) _____
Best time and place to reach you _____

## INCASE OF EMERGENCY CONTACT

Name _____ Relationship _____
Home Phone ( ___ ) _____
Work Phone ( ___ ) _____

## INSURANCE INFORMATION

_____
Who is responsible for this account?

_____
Relationship to Patient

_____
Insurance Co.

_____
Group #
Is patient covered by additional insurance?
☐ Yes ☐ No

_____
Subscriber's Name

_____
Birthdate

_____
SS#

_____
Relationship to Patient

_____
Insurance Co.

_____
Group #

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of insurance company) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will and when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Print name of Patient, Parent, Guardian, or Personal Representative

_____
Date Relationship to Patient

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## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

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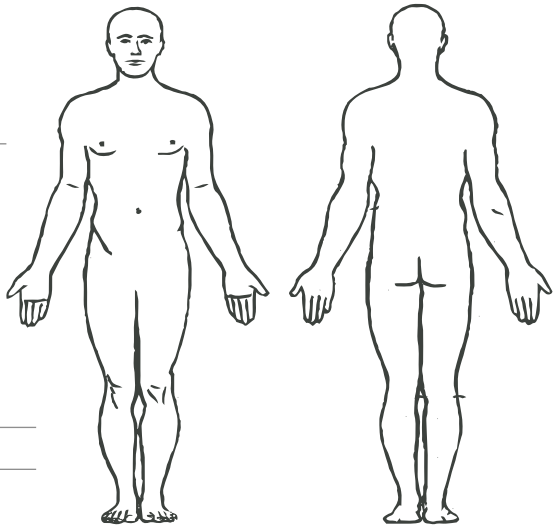

## 5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing

☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

## 6 HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

_____

Name and address of other doctor(s) who have treated you for your condition

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test

Spinal Exam _____ Chest X-Ray _____ Urine Test

Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Goiter | ☐ Yes | ☐ No | Pinched Nerve | ☐ Yes | ☐ No |
| Alcoholism | ☐ Yes | ☐ No | Gonorrhea | ☐ Yes | ☐ No | Pneumonia | ☐ Yes | ☐ No |
| Allergy Shots | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Polio | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Prostate Problem | ☐ Yes | ☐ No |
| Anorexia | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No |
| Appendicitis | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Herniated Disk | ☐ Yes | ☐ No | Rheumatoid Arthritis | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Herpes | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Breast Lump | ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No | Sexually Transmitted Disease | ☐ Yes | ☐ No |
| Bronchitis | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Bulimia | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Suicide Attempt | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Measles | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | Migraine Headaches | ☐ Yes | ☐ No | Tonsillitis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Miscarriage | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chicken Pox | ☐ Yes | ☐ No | Mononucleosis | ☐ Yes | ☐ No | Tumors, Growths | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No | Typhoid Fever | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No | Mumps | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Vaginal Infections | ☐ Yes | ☐ No |
| Fractures | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Other | | |
| Glaucoma | ☐ Yes | ☐ No | Parkinson's Disease | ☐ Yes | ☐ No | | | |

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## EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

## WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

## HABITS
- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

## INJURIES/SURGERIES

| | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## 7 MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (___) _____

## FAMILY HEALTH HISTORY

Please "X" mark the following that your family has experience in the past:

- o AIDS/HIV
- o Alcoholism
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis (What type & where)
- o Asthma
- o Bleeding Disorders
- o Breast Lump (Please explain)
- o Bronchitis
- o Bulimia
- o Cancer (What type & where)
- o Chemical Dependency
- o Diabetes
- o Depression
- o Emphysema
- o Epilepsy
- o Fractures (Where & how?)
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herniated Disc (what level & how did this occur?)
- o High Cholesterol
- o Kidney Disease
- o Liver Disease
- o Migraine Headaches
- o Multiple Sclerosis
- o Osteoporosis
- o Pace Maker
- o Parkinson's Disease
- o Pinched Nerve
- o Pneumonia
- o Polio
- o Prostate Problems
- o Psychiatric Care
- o Rheumatoid Arthritis
- o Stroke
- o Thyroid Problems
- o Tumor (Please detail)
- o Ulcers
- o Whiplash (When?)
- o Previous Chiropractic Care
  Last date of treatment:
  By Whom? _____
  For What? _____

Patient Signature _____ Date _____

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## CLIENT CONFIDENTIALITY AGREEMENT (HIPAA FORM)

Honoring confidentiality is important. Healthcare Professionals are required by law to let you know the ways we may use and disclose information about you and your treatment. This notice describes your rights and our obligations regarding this information. **Please review it carefully and ask any questions that arise at any time.**

We may disclose your therapy information using some or all of the following methods: electronic mail (email), facsimile (fax), telephone, cell phone, voice mail, answering machine, written communication by mail, and verbal in-person.

**Client Rights:** Clients may request in writing to see or obtain a copy of their records. A fee may be charged for copying and sending requested records.

**Disclosure of Records:** We may communicate about your therapy information with professionals involved in other facets of your care, such as providing information to your medical insurance or other practitioners who are treating you. We will do so only with your express written authorization. The court also may require disclosure via subpoena.

I, (please print) _____ have read and understand this privacy policy. If applicable, I give my permission to discuss my therapy and pertinent details with the following individuals and groups (can leave blank if not applicable)

Name/Phone Number

_____

_____

_____

_____

Your Signature (and your guardian's if your under 18 years old)

_____

Date:

_____

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## FINANCIAL POLICY – PLEASE READ CAREFULLY
## (UPDATED 01/01/2018)

**Insurance:**
Our office will provide insurance verification as a courtesy for our patients to determine if your coverage includes Chiropractic and Massage benefits. If you do, our office will submit your claims for your treatment on your behalf to your insurance carrier.

o Health Care and accident insurance policies are an arrangement between an insurance carrier and the subscriber/patient, and said **patient is personally responsible for services rendered**.

o All copays, coinsurance, and deductibles are collected at the time of service, payment will or collected from the patient on the day that services are rendered, unless you have made prior arrangements with the billing coordinator or office manager.

o **We strongly recommend you verify your own benefits, as the contract between you and your insurance, and whatever was quoted to you is binding**. Ultimately, it is your responsibility to know what your benefits are.

**Cash:**
Cash payments will be collected at the time or services rendered. We offer payment plans to help you finance your treatment. Please feel free to ask the front desk about our plans.

**Workers' Compensation:**
You need to report your accident to your employer, bring in necessary documentation of the accident and insurance information (if applicable). Complete and sign the accident report and L&I forms. Until your claim is approved or denied, you may be required to pay acquired fees on a cash basis.

**Personal Injury:**
You will need to provide the office with the following information: accident report, police report, your car insurance information, the other party's information, your attorney information and the other party's attorney Information (if applicable). It is our office policy that you obtain an attorney if you do not have PIP (personal injury protection), if you do not have an attorney please let us know so that we can further assist you in obtaining legal representation. If you do have an attorney and have no PIP or have maxed out your PIP we will work under a medical lien RCW 60.44.010.

**Appointment Cancellation Policy:**
All patients that **no show** or **cancel** without 24 hours' notice will be charged $60 for Chiropractic and $60 for Massage appointments. After the third no show visit, you will be required to pay for any appointments scheduled ahead of time, and refunded any extra amount upon keeping the scheduled appointment.

By signing below, you certify you have read, understand and agree to the Financial Policy and Appointment Cancellation Policy for the practice.

- You also understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and yourself, and that all services rendered to you and charged are your personal responsibility.
- You understand that if you suspend or terminate your care/treatment, any fee for professional services rendered to you will be immediately due and payable.
- You also understand that text/email reminders are a courtesy and you are still responsible for the appointment even if you do not receive the reminder text/email.

Patient Name: _____ _____
Please Print Date

Patient Signature: _____

Courtesy appointment reminder: Text: cell number: _____

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## INFORMED CONSENT FOR TREATMENT (01/09/2018)

Medical Doctors, Chiropractic Doctors, Osteopaths and Physical Therapists that perform manipulation are required by law to obtain your consent before starting treatment.
I, _____ do here by give my consent to perform conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustment involving movement of the joints and soft tissues, physical therapy and exercise may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows.
- Soreness – I am aware that like exercises it is common to experience muscle soreness in the first few treatments.
- Dizziness – Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Fractures/Joint Injury – I further understand that in isolated cases underlying physical defects, deformities pathologies like weak bones from osteoporosis may render the patient susceptive to injury. When osteoporosis, degenerative disk or other abnormality is detected, this office will proceed with caution.
- Stroke – Although strokes will happen with some frequency in our world, strokes from chiropractic adjustments are rare.
I am aware that nerve or brain damage including stroke is reported to occur in one million to once in ten million treatments. Once in a million is about the same chance as a normal dose of aspirin or Tylenol causing death.
- Physical Therapy Burns – Some of the therapies used in the office generate heat and may rarely cause a burn. Despite precautions if a burn is obtained there will be a temporary increase of pain and possible blistering, this should be reported to the doctor.
- Bruising – Bruising will occur at the site of a Chinese cupping session, this is toxins being lifted to the surface. Very rarely bleeding will occur at the site of an acupuncture needle.
Tests have been preformed on the doctors to minimize the risk of any complication from treatment and freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatments procedures including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I achieve these benefits.
I realize that the practice of medicine; including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree to the performance of these procedures by my doctor and such other persons choosing alternative treatments available.

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter medications, exercise and possible surgery.
Medications – Medications can be used to reduce pain of inflammation. I am aware that long term use or overuse of medication is always a cause of concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/exercise - It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissue.

Surgery – Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to the anesthesia, and prolonged recovery.

Non-Treatment – I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion, inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have been read the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my consent form. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to the authorization for treatment.

Date: _____

Signature of patient: _____

Signature of legal representative: _____

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I, _____, hereby authorize and direct you my attorney, to pay directly to Higher Health Spine and Sport such sums as may be due and owing for health care services for injuries arising from the motor vehicle accident of _____ . I hereby authorize my attorney and involve insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor or his/her office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempt to rescind will not be honoured by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly responsible to said doctor or his/her office for all health care bills submitted by him/her for services rendered me. Further, this agreement is made solely for said doctor's additional protection and in consideration of his forbearance on payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages.

Also, I understand that my responsibility to pay Higher Health Spine and Sport right to file lien to protect its financial interest under RCW 60.44.

I authorize Higher Health Spine and Sport to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.01, et seq. I understand I may then be asked to make minimum monthly payment on any balance owed. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien. I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to Higher Health Spine and Sport for treatment provided, and I may be required to make additional payment after satisfaction of the lien.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current basis.

Dated this _____ day of _____ , 20 , at _____ , Washington.

Signed: _____ (Patient)

Date of Automobile Collision: _____

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## FINANCIAL AGREEMENT – PERSONAL INJURY

All new patients will have a chiropractic examination and, if necessary, x-rays to determine the extent of the injury or condition. A course of appropriate treatment will be recommended.

| Fees | |
|---|---|
| Initial examination | $200 and up |
| Spinal adjustment | $ 75 and up |
| One Hour Massage | $160 |

As a courtesy to you, we will bill your personal injury protection (PIP) insurance coverage. We will ask you to sign an Assignment of Benefits form for direct payment to us. If you do not have this coverage, we will bill your health insurance carrier after receiving written notice that they agree to accept responsibility for payment. You will be personally responsible for any amount that the insurance company does not pay. Until we have the appropriate information to carry out this billing, your account will be on a cash payment basis.

If you miss an appointment without giving 24 hours' notice, you will be charged a fee for the visit, which will be due in full at the time of your next appointment. There will be a $20 service fee for any check returned due to insufficient funds.

In the event that your account is placed with an agency for collection, you will be responsible for paying any and all costs that might be incurred. If you suspend or terminate care at this office, all outstanding charges will be due and payable immediately.

---

I acknowledge that I have read and understood this document, agree to abide by its contents, and have been given a copy for my records.

Signature of patient/guardian Date

Signature of Staff Date

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## ACCIDENT INFORMATION

Date: _____

Patient Name _____ Account # _____

Date of accident _____ Time of accident _____

_____ _____

City State

Insurance company name _____

Claim mailing address _____

_____

Claim Adjuster Name _____

Claim Adjuster Phone # _____

Policy # _____

Claim # _____

Is this Personal Injury Protection (PIP) coverage? Yes No

---

If another person is responsible:

Name _____

Address _____

Insurance company name _____

Claim mailing address _____

_____

Claim Adjuster Name _____

Claim Adjuster Phone # _____

Policy # _____

Claim # _____

Attorney's name and phone # _____

Did the police come to the accident? Yes No was a ticket issued? Yes No

Were you taken to the hospital? Yes No

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The following questions pertain to you, the patient, and the car that you were in:

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You were the:
_____Driver
_____Front seat passenger
_____Back seat passenger
_____Pedestrian

You were wearing:
_____No seatbelt
_____Lap seatbelt only
_____Shoulder-Lap Seatbelt

Upon impact/ Collision you were:
_____Caught by Surprise
_____Aware of the approaching vehicle

Did you lose consciousness?
_____Yes- For how long?_____
_____No

The headrest of your car seat reaches:
_____Above your head- By how many inches?_____
_____Below your head- By how many inches?_____
_____There is no headrest

Make of your vehicle: _____
Model of your vehicle:_____
Year of your vehicle: _____
Size of your car:
_____Small/Compact
_____Mid-sized
_____Large

At the time of the impact, your car was:
_____Stopped
_____Moving –How fast? _____

Was your foot on the brake at the time of the impact?
_____Yes
_____No

If your vehicle was moving at the time of the impact, were you:
_____Slowing down
_____Accelerating
_____Traveling at a steady rate

Were you:
_____Hit from the BACK
_____Hit on the RIGHT side of your car
_____Hit on the LEFT side of your car
_____Hit in the FRONT of your car

Was your head:
_____Straight forward
_____Turned to the RIGHT
_____Turned to the LEFT
_____Other: _____

Was your body:
_____Straight forward
_____Turned to the RIGHT
_____Turned to the LEFT
_____Other: _____

Did any of the following parts of your body strike any part of the car?
_____Head
_____Chest
_____Shoulder/ Arm – What side?_____
_____Knee/ Leg – What side?_____
_____Other: _____

What is the cost of damage to vehicle that you were in? _____
Make of your vehicle:_____
Model of your vehicle: _____
Year of your vehicle: _____
Size of your car:
_____Small/Compact
_____Mid-sized
_____Large

At the time of impact, the other car was:
_____Stopped
_____Moving – what speed?_____

If the other vehicle was moving at the time of the impact, were you:
_____Slowing down
_____Accelerating
_____Traveling at a steady rate

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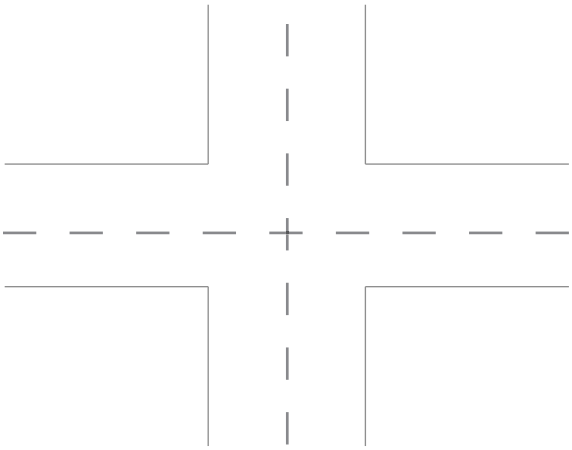
A

= Your Car

B

= Other Car



Please describe the accident in your own words. Please use the above diagram to indicate the position of the cars involved:

_____

_____

_____

Please describe how you felt: _____

A. DURING the accident: _____

B. IMMEDIATELY AFTER the accident: _____

C. LATER THAT DAY: _____

D. THE NEXT DAY: _____

Did you have any physical complaints BEFORE THE ACCIDENT?

_____YES

_____NO

If yes, please describe in detail:

_____

_____

_____

Have you ever been involved in an accident before?

_____YES

_____NO

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

_____

_____

_____

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## CREDIT CARD/HSA/FSA AUTHORIZATION

Patient Name: _____

Cardholder Name: _____

Phone number: _____ (used for courtesy call before CC charged)

Card Information:

Card Type: _____

Card Number: _____

Expiration Date: _____

Allowed Amount to be charged each date of service: $ _____ while meeting DEDUCTIBLE

Allowed Amount to be charged each date of service: $ _____ for individual copay or co-insurance (after DEDUCTIBLE has been met)

☐ I authorize _____ to hold my credit card information in my file. I authorize _____to charge this credit card directly for my medical deductible, particular co-pay or co-insurance payment amount. I certify that I am a person who is authorized to use this credit card.

_____

Signature: Date:

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## CONSULTATION NOTES

**PATIENT** _____

**DATE** _____

1) CHIEF COMPLAINT _____

2) IS THIS YOUR FIRST VISIT TO A CHIROPRACTOR? Y/N
3) ONSET/CAUSE (RELATED TO AUTO ACCIDENT?) _____

4) HAS THIS HAPPENED BEFORE? Y/N
5) NUMBNESS IN HANDS/LEGS/FEET? Y/N
6) WEAKNESS? Y/N _____
7) DO YOU HAVE ANY UNKNOWN FRACTURES/TRAUMAS? Y/N

8) DESCRIBE YOUR PAIN: SHARP DULL THROBBING STABBING BURNING

9) OTHER DOCTORS SEEN FOR THIS CONDITION? Y/N WHO?

_____

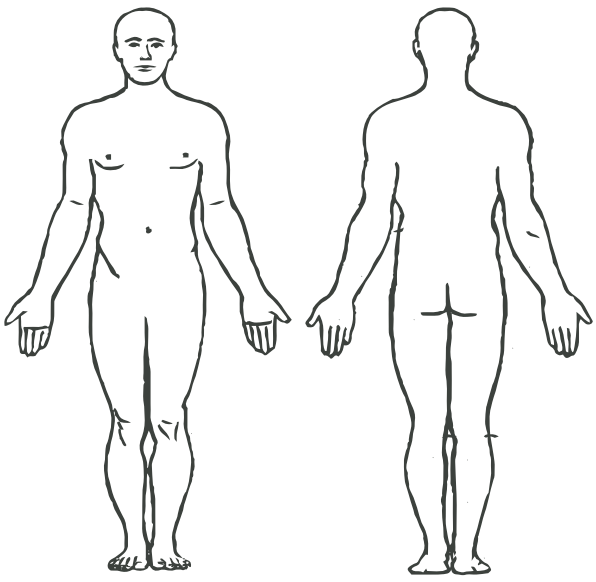
10) SURGERIES? Y/N

_____

11) MEDICATIONS Y/N

_____

12) SCALE OF /10 CERVICAL /10 THORACIC /10 LUMBAR /10 OTHER
13) WHEN DO YOU EXPERIENCE PAIN? ALL OF THE TIME AM PM AT WORK
14) ANY MEDICAL CONDITIONS? Y/N _____
15) LAST VISIT TO GENERAL PRACTITIONER, LAST PHYSICAL
16) FAMILY HISTORY OF MEDICAL CONDITIONS? Y/N
17) HOW SEVERE IS THE PAIN? SCALE OF /10 PRIMARY PAIN AREA OF PAIN
/10 SECONDARY AREA
/10 THIRD AREA
18) DRAW AN 'X' ON THE FIGURE TO DESCRIBE AREA OF PAIN:



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