PRE-ADULT PATIENT FORM

DATE ______________ PATIENT NUMBER ___________

PATIENT INFORMATION

NAME ________________________________ DATE OF BIRTH ________________

SSN ______________________ PHONE NUMBER _________________________

ADDRESS ____

____

REFERRED BY _____________________________ STUDENT: YES NO

PARENT / GUARDIAN INFORMATION

NAME OF PARENTS / GUARDIAN ____

PHONE NUMBER ___________________ WORK NUMBER ____________________

ADDRESS (IF DIFFERENT) ____

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MAJOR COMPLAINTS:

	PAIN	*NUMBNESS*	*TINGLING*
HEAD	( )	( )	( )
NECK	( )	( )	( )
UPPER BACK	( )	( )	( )
MID BACK	( )	( )	( )
LOW BACK	( )	( )	( )
SHOULDER	( )	( )	( )
ARM	( )	( )	( )
HAND	( )	( )	( )
BUTTOCK	( )	( )	( )
HIP	( )	( )	( )
LEG	( )	( )	( )
FOOT	( )	( )	( )

IS CONDITION DUE TO AN AUTO ACCIDENT ( ), FALL ( ), OTHER ( )

ILLNESSES: *HAVE YOU EVER OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING?*

	Y	N		Y	N
ASTHMA	( )	( )	HEART	( )	( )
SINUS TROUBLE	( )	( )	HIV / AIDS	( )	( )
DIABETES	( )	( )	CANCER	( )	( )
EPILEPSY	( )	( )	POLIO	( )	( )
KIDNEY TROUBLE	( )	( )	EMOTIONAL DISORDER	( )	( )
MENTAL DISORDER	( )	( )	OTHER	( )	( )