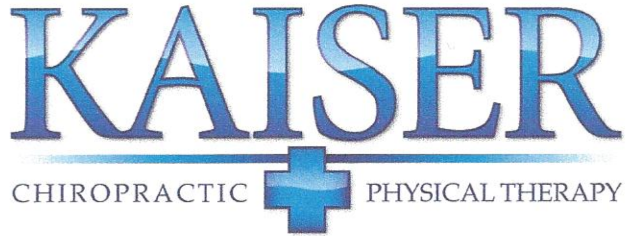

Registration Form

Patient Name: ________________________________ Date: ______________

Address: ______________________ City: _____________ State/ZIP __________

Email Address: ____

Date of Birth: ________ Home #: __________ Cell #: _________ Work #: ________

Age: ___ Marital Status: ____________ Social Security #: ________________

Employer: ________________ Address: ______________________________

How did you hear about our office? ______________________________________

Primary Medical Doctor (MD): __________________ City/State: _____________

Spouse/Emergency Contact: _________________ Phone #: __________________

Primary Complaint (#1 Reason for seeing the doctor today): ____________________

Onset Date: ______ Frequency (circle): constant frequent occasional intermittent

Intensity (minimal "0" – severe "10") 0 1 2 3 4 5 6 7 8 9 10

Type (circle) dull ache sharp shooting stiffness numb/tingling weakness burn

Aggravated by: __________________ Relieved by: __________________

Past History of this Condition?: ____ Treated?: ____ Type of treatment: ________

Tests performed (circle): X-ray MRI CTScan NCV/EMG Other: __________

(Please initial and date the bottom right hand corner of each page)