

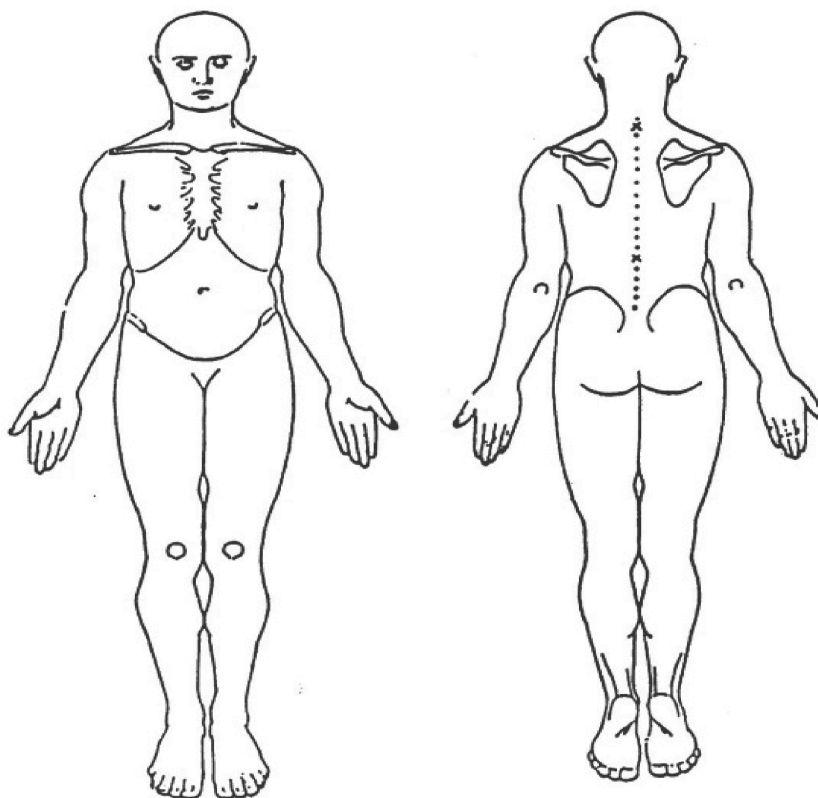


# New Patient Packet

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## PRESENT CONDITION: PAIN / TENSION

Please place an “X” in the area or areas where you are experiencing pain / symptoms. Then use the descriptions of pain below to indicate the type of pain in each area that you marked by drawing an arrow from each specific type of pain to that marked area.



- |                 |                            |  |                 |
|-----------------|----------------------------|--|-----------------|
| <b>SEVERE</b>   | <b>DULL</b>                | <b>STABBING</b>                                  | <b>MODERATE</b> |
| <b>BURNING</b>  | <b>NUMBNESS / TINGLING</b> | <b>THROBBING</b>                                 |                 |
| <b>WEAKNESS</b> | <b>SHARP</b>               | <b>RADIATING</b> (INDICATE DIRECTION WITH ARROW) |                 |

Please list each symptom that you are experiencing & rate each on a scale of 0 – 10.  
(0 being no pain and 10 need to be taken to the hospital)

| <b>Symptoms:</b> | <b>Severity</b>        |
|------------------|------------------------|
| _____            | 0 1 2 3 4 5 6 7 8 9 10 |
| _____            | 0 1 2 3 4 5 6 7 8 9 10 |
| _____            | 0 1 2 3 4 5 6 7 8 9 10 |
| _____            | 0 1 2 3 4 5 6 7 8 9 10 |

Date of injury onset \_\_\_\_\_

What initially caused your pain? \_\_\_\_\_

Have you had a related surgery? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If yes, what was the date? \_\_\_\_\_

Since it has started, has the pain changed? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Have your symptoms become **Worse** \_\_\_\_\_ **Better** \_\_\_\_\_ **The Same** \_\_\_\_\_

How often do you experience the pain? \_\_\_\_\_

What makes your symptoms worse?

**Sitting** \_\_\_\_\_ **Standing** \_\_\_\_\_ **Lifting** \_\_\_\_\_ **Bending** \_\_\_\_\_

How much does your pain interfere with your activities?

**Daily Activities**    **Extra-Curricular**

\_\_\_\_\_ Between 1 – 20% of the time

\_\_\_\_\_ Between 20 – 40% of the time

\_\_\_\_\_ Between 40 – 60% of the time

\_\_\_\_\_ Between 60 – 80% of the time

\_\_\_\_\_ Between 80 – 100% of the time

Are you taking any medication? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If yes, please list medications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you have, or have you had, any of the following?

- Anemia
- Asthma
- Back Pain
- Cancer
- Depression
- Disc Problems
- Dizziness / Fainting
- Heart Attack
- Hypoglycemia
- Kidney Problems
- Low Blood Pressure
- Metal Implants
- Neck Pain
- Osteoporosis
- Pacemaker
- Rheumatoid Arthritis
- Seizures
- Stroke
- Tingling In Arms / Hands
- Vision Problems
- Allergies
- Balance
- Bowel / Bladder Issues
- Chest Pains
- Diabetes
- Headaches
- Excessive Fatigue
- High Blood Pressure
- Knee Pain
- Liver / Gallbladder Problems
- Low Exercise Level
- Nausea / Vomiting
- Neck Stiffness
- Osteoarthritis
- Poor Diet
- Ringing In Ears
- Shortness Of Breath
- Thyroid Problems
- Tingling In Legs / Feet
- Other Health Issues (*please explain*)

Please explain any checked items \_\_\_\_\_

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**WORK**

Are you currently working? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If yes, how many hours a week? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Please describe what you do at your job \_\_\_\_\_

\_\_\_\_\_

I have read and reviewed the information herein and represent that the same is true, correct and complete. I understand that ActiveRx and its health practitioners are relying upon the information in rendering treatment.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_