What is the reason for your visit? **Please indicate what body part and if it is LEFT or RIGHT.**
_____

How and when did the problem occur?
_____
_____
_____

Level of your Pain:	**Pain Scale 0-10**
What is your pain level today?	_____
Pain level at its worst?	_____

Type of Injury:	**YES or NO**
Auto accident related?	_____
Injury related?	_____
Employment related?	_____

Do you have any major illness or disease (such as diabetes, high blood pressure, heart disease, etc.)?
YES_____ NO_____
_____
_____

Have you had previous surgery? Please give dates.
YES_____ NO_____
_____
_____

Are you allergic to any medications? Please list.
YES _____ NO_____
_____
_____

Are you presently taking any medications? Please list.
YES_____ NO_____
_____
_____

Do you or have you ever smoked? YES___ NO___ If yes, how much and when_____

If Yes, would you like information on resources to quit smoking? Yes ____ No ____

Do you drink alcoholic beverages? YES___ NO___ If yes, how often _____