LEFEBVRE CHIROPRACTIC
20 Saratoga Ave
Waterford, New York 12188

Last Name: _____First Name _____Male ____Female ____ Age_____ Date of Birth_____

Address _____City _____State ____Zip _____

Home Phone # _____Work Phone # _____ Cell # _____ Email _____

Primary Physician's Name _____ Phone # _____

Current work status: Full time ____ Part time ____ Current job duties _____

Retired _____ Disabled _____

Present weight _____ Height _____

Describe your complaint _____

When did your problem occur? Date _____ Work _____ Auto _____ Other _____

How problem occurred _____

Have you been treated for this problem by another health care provider? No ___ Yes ___ Name of Provider _____

Have you had this problem or a similar problem in the past? Yes ____ No ____

If yes, please describe _____

What makes your problem worse _____What makes it better _____

Indicate your pain level: 0 ___ 1___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

Characterize your pain:

Sharp___ Ache ___ Dull ___ Burning ___

Tingling ___ Griping ___Shooting ___

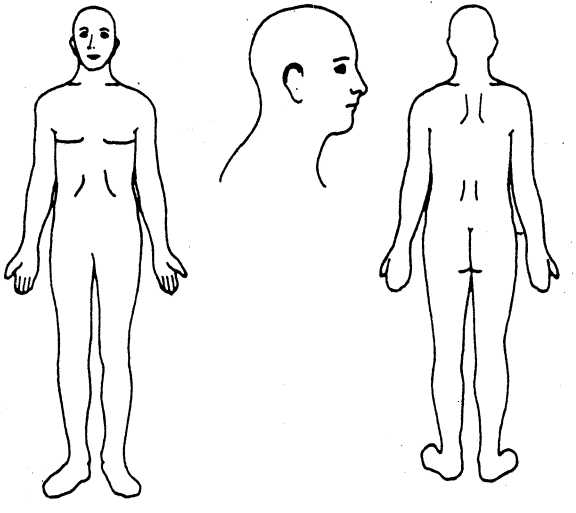
Numbness ___ Throbbing ___ Weak ___

Describe frequency of your pain:

Intermittent (0-25%) ___ Occasional (25-50%) ___

Frequent (50-75% ___ Constant (75-100%) ___

Please mark your areas of pain on the figures below.



Patient Signature_____ Date: _____

Witness _____ Date: _____