

- Dr. Chapin, DC
- Dr. Fligg, DC
- Dr. Danson, DC
- Dr. Weinberg, DC
- Dr. Neale, DC
- Dr. Sawa, DC
- Dr. Welsh, DC
- Z. Herskovits, P.T.
- D. Armena, P.T.
- E. Tanubrata, P.T.



1977 – 2019 Providing Over 40 Years of Exceptional Patient Care

- Dr. K. Harpell, ND
- Dr. N. Litvak, ND
- G. Padriue, RMT
- A. Jurkiewicz, RMT
- S. Forrester, RMT
- M. Bogovic, RMT
- M. Parsons, RMT
- M. Malloy, RMT
- N. Qureshi, RD

Date: \_\_\_\_\_ **New Condition Patient Information**

**Dr.'s Comments**

**Reason For Appointment:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day yr

Home Phone# \_\_\_\_\_ work# \_\_\_\_\_ cell# \_\_\_\_\_

When did your condition begin? \_\_\_\_\_

Is this condition related to:  Occupation  Car Accident  Home Injury  
 Fall  Sports Injury  Other

Has this condition occurred before? Yes  No

Have you seen any other Health Professional for this condition? No  Yes

Type \_\_\_\_\_ Results: \_\_\_\_\_

Are you taking any medication for this condition? No  Yes  \_\_\_\_\_

Is your pain worse in the... Morning  Mid-day  Evening  All Day Long

Rate your pain on the following scale (circle)... 1 2 3 4 5 6 7 8 9 10  
mild...>...moderate.....>...severe

What aggravates your pain? \_\_\_\_\_

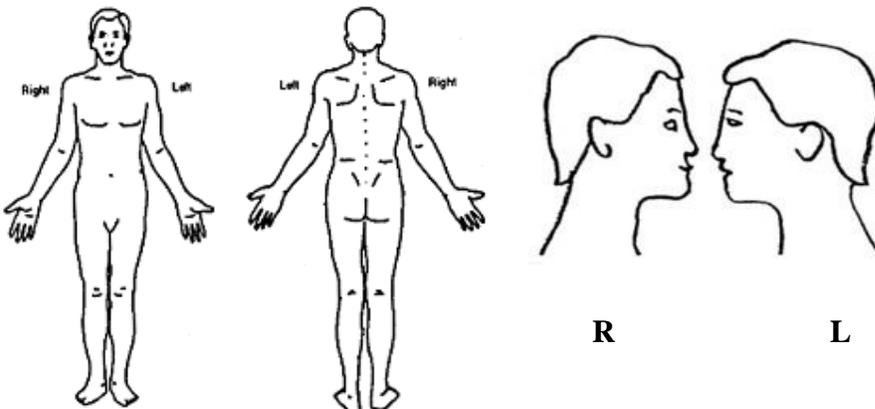
What gives you relief? \_\_\_\_\_

Does the pain affect your work, family, life, or recreational activities? **No**  **Yes**

Does this problem cause you stress, anxiety, depression...? **No**  **Yes**

Have you had X-Rays/CT, MRI, bone density taken? **No**  **Yes**  Date: \_\_\_\_\_

Location: \_\_\_\_\_



**LOCATION & SEVERITY OF PROBLEM**

<b>Symptom</b>	<b>L</b>	<b>R</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Headache					
Neck					
Shoulder					
Arm					
Elbow					
Wrist					
Hand					
Upper Back					
Chest (Ribs)					
Low Back					
Hip					
Thigh					
Knee					
Lower Leg					
Ankle					
Foot					
Other					
<b>PLEASE DESCRIBE YOUR PAIN</b>					
Stiffness					
Aching					
Burning					
Throbbing					
Sharp					
Stabbing					
Numbness					
Tingling					
Pressure					

**Dr.'s Comments/Examination**

In the event that I am not available to answer the phone when called by the staff of the HPWC I hereby authorize the staff to leave a message for me regarding the details of my appointment at the phone numbers provided.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Diagnosis/Clinical  
Impression/Treatment  
Recommendations**