Willow Bend Sports & Spine Center
Patient Intake Form

Name: ______________________________ Date: ______________________

Date of Birth: __________________________ Contact PH#: _______________

NOTE: Laser Therapy is NOT included in Office Visit and is an additional $25

1. What is the "main" reason for your visit? ______________________________________

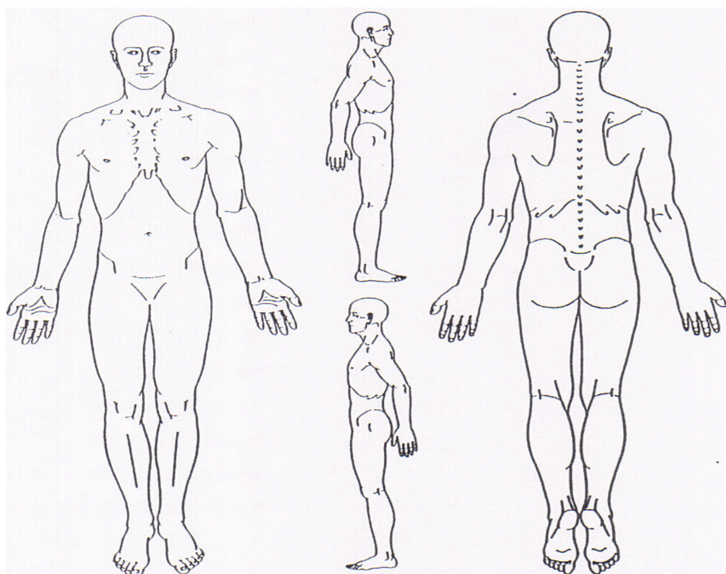
2. On the scale below, please indicate the severity of your main complaint (circle one)

(None) 0 1 2 3 4 5 6 7 8 9 (Severe)

3. Please indicate the overall improvement of your condition since your initial visit

No Change 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Use the diagram and symbols below to show where you are currently experiencing your main complaint today:



A = Aching	B = Burning
C = Cramping	D = Dull
N = Numbness	S = Sharpness
P = Pins/Needles	ST= Stabbing
^^^ = Shooting	/// = Throbbing
+++ = Tingling	T = Tightness
O = Other:____________________	

5. Please describe ALL details concerning your main complaint:

©2016 Willow Bend Sports & Spine Center | All Rights Reserved 06.16