Office Use Only
PATIENT ID_____

DR._____

RELIEF & RENEW
CENTER

680 N. Germantown Parkway, Suite 44. Cordova, TN. 38018 (901) 207-3247

Name_____Today's Date_____

Address_____City_____St._____Zip_____

Best Phone Number to Reach You_____ Email Address_____

Date of Birth_____ Age:_____ Sex: ( ) Male ( ) Female Number of Children_____

Employer_____Occupation_____

Marital Status (circle one) M S D W

Spouse's Name_____

How did you hear about us?_____

Are you currently under the care of another physician?
( ) Yes ( ) No
If yes, please list the reason(s) and the name of the
provider:_____

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Reason for visit: ( )Neuropathy ( ) Knee Pain-R/L ( ) Plantar Fasciitis ( ) Neck Pain ( )Back Pain-Mid/Low
( )Shoulder Pain-R/L ( )Other_____

Date problem began_____

How problem began_____

Is this auto related? YES or NO

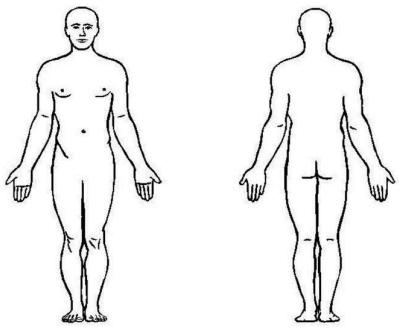
Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

Do you have any of the following conditions? (Check all that apply)
( ) Pacemaker
( ) Blood Clots
( ) Diabetes
( ) Cancer (past or present)
( ) Other (please specify):_____

Please Complete Back Side

Circle all of the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Unbearable	Miserable	Exhausting
Stabbing	Tiring	Gnawing



Please mark an **X** on the picture where you have pain or other symptoms.

Circle the number that best describes your pain RIGHT NOW.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable.

What makes your pain <u>BETTER?</u> _____

What makes your pain <u>WORSE?</u> _____

How often are your symptoms present?

(Occasional) ( ) 0-25% ( ) 26-50% ( ) 51-75% ( ) 76-100% (Constant)

Please list ALL MEDICATIONS you are currently taking.

_____

Please list any surgeries you have had.

_____

Check any of the following you have had in the last six months:

( ) Headaches
( ) Sinus Congestion / Allergies
( ) Vision Problems
( ) Earaches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea/ Vomiting
( ) Abdominal Cramps
( ) Constipation/ Diarrhea
( ) Discolored Urine
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful/ Excessive Urination

I authorize Relief and Renew Center to render necessary services to me and I am responsible for all charges incurred.

Patient/ Guardian Signature_____Date_____