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PERSONAL HEALTH HISTORY- To be completed by Patient Prior to Office Visit

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Chadfield will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and **whether the practice will accept you as a patient.**

_____
Last Name First Name Middle Initial

Age: _____ Date of First Visit: _____

Who is your Primary Care Physician?

Name: _____ Phone: _____

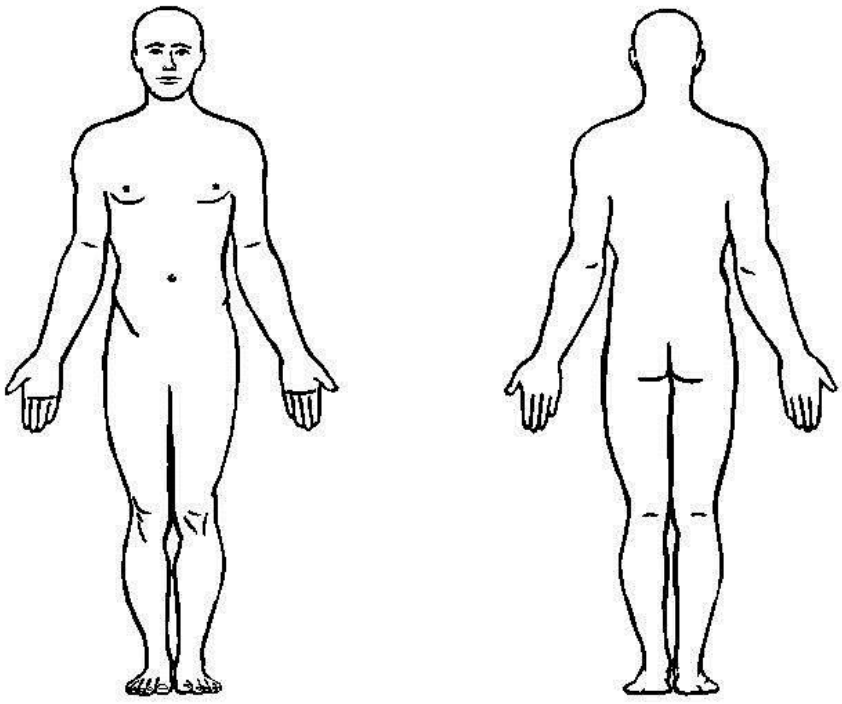
Address: _____

Please list who referred you to this clinic?

Name: _____

Mark the areas on your body where you feel pain now or regularly
Use the appropriate codes indicated below.

ACHE >>>>	NUMBNESS ---------	PINS & NEEDLES 000000	BURNING xxxxx	STABBING //////
>>>>	---------	000000	xxxxx	//////
>>>>	---------	000000	xxxxx	//////



What number is your pain at worst _____ when best _____ today _____(0 no pain/10 worst pain)