STEVEN J. TUNNELL, DC

DIPLOMATE OF THE AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS

CERTIFIED STRENGTH AND CONDITIONING SPECIALIST

QUALIFIED MEDICAL EVALUATOR

Name _____

Address _____

City _____ State_____

Zip _____ Date of birth _____/_____/_____

Home telephone # _____
Work telephone # _____
Cellular phone#_____
E-mail address _____
Social security # _____

Marital status : single _____ married _____ widowed _____divorced _____

Insurance company _____

Policy # _____

Group # _____

Relationship to insured : self _____ spouse _____
dependent _____

If spouse or dependent: Insured's name _____

Insured's social security # _____

Area of complaint _____
_____
_____

Did this injury occur at work and is a workman's compensation case? _____

Did this injury occur as the result of an automobile accident or other accident, and if so, is this a personal injury case? _____

Have you ever been hospitalized before? _____

If yes, when and for what reason ?_____
_____

Occupation_____

What exercises do you perform? (or what sport do you participate?)
_____
_____

Who was your referral source?_____

Home and telephone # of someone to contact in case of an emergency
_____ Phone _____

Are you seeing any other physician of any type, for any reason? _____
If yes, who? _____

In the following space, please place "1' for "have now", and "2" for "had", and leave the space blank for "never had".

_____ heart attack
_____congestive heart failure
_____high blood pressure
_____stroke
_____cough up phlegm
_____pneumonia
_____seizures
_____kidney stones
_____currently pregnant
_____vaginal discharge
_____breast soreness
_____prostate disorders
_____tuberculosis
_____liver disease
_____heartburn
_____intestinal disease
_____alcohol / substance abuse
_____smoke cigarettes
_____large weight gain / loss
_____hepatitis
_____rheumatic fever
_____allergies
_____measles
_____mumps
_____whooping cough
_____herpes simplex
_____HIV+
_____hernia
_____blood in stools
_____hemorrhoids
_____scarlet fever
_____chicken pox
_____dizziness
_____fainting
_____rapid heart rate
_____chronic cough
_____eye strain
_____visual disturbances
_____painful urination
_____kidney disease
_____birth control pills
_____menopause problems
_____osteoporosis
_____cancer
_____diabetes
_____ulcer
_____Epstein-Barr virus
_____chronic fatigue syndrome

In the following space, please place "1' for "have now", and "2" for "had", and leave the space blank for "never had".

_____arthritis
_____pain in knees
_____pain in ankles
_____pain in feet
_____pain in shoulders
_____pain in elbows
_____pain in wrists
_____pain in hands
_____pain in hip
_____history of gout in family
_____neck pain
_____low back pain
_____pain or tingling radiating down arm
_____pain between shoulder blades
_____pain or tingling radiating down leg
_____any other pain? If so, please explain _____
_____
_____

Current medication: _____
_____

What are your expectations from treatment?
_____
_____
_____

My signature below, gives my informed consent, for Steven J. Tunnell, DC or his assistant, to take a medical history, perform a physical examination, derive a diagnosis, order tests if indicated, and/or render treatment as indicated.

_____ _____
Patient signature Date