SoftWave
Tissue Regeneration Technologies

SYMMETRY
CHIROPRACTIC & ACUPUNCTURE

TRT Treatment Patient Info

First Name _____ **Last Name** _____

Prefer to be called: _____ **Birthday:** _____ **Age:** _____

Gender:
◯ Male ◯ Female

SS#: _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Email Address (Home): _____ **Email Address (Work):** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Preferred Method of Contact:
◯ Home Email ◯ Work Email ◯ Home Address
◯ Home Phone ◯ Cell Phone ◯ Work Phone

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____

Whom may we thank for referring you?
◯ Google ◯ Facebook ◯ Person ◯ Other

Explain: _____

Major Complaint: _____ **Secondary Complaints:** _____

Describe WHEN and HOW this began: _____

Grade Intensity/Severity of Complaint:
◯ None (0) ◯ Mild (1-2) ◯ Mild-Moderate (2-4)
◯ Moderate (4-6) ◯ Moderate-Severe (6-8) ◯ Severe (8-10)

Quality of the Complaint/Pain:

- [ ] Sharp
- [ ] Stabbing
- [ ] Burning
- [ ] Achy
- [ ] Dull
- [ ] Stiff & Sore
- [ ] Other

If Other, please explain:

How frequent is the complaint present?

- ◯ Off & On
- ◯ Constant

Does this complaint radiate/shoot to any areas of your body?

- [ ] No
- [ ] Yes

If so, Where?

Does anything make the complaint better?

- [ ] Ice
- [ ] Heat
- [ ] Rest
- [ ] Movement
- [ ] Stretching
- [ ] OTC
- [ ] Other

If Other, please explain:

Does anything make the complaint worse?

- [ ] Sit
- [ ] Stand
- [ ] Walk
- [ ] Lying
- [ ] Sleep
- [ ] Overuse
- [ ] Other

If Other, please explain:

Which daily activities are being affected by this condition? (Describe):

Had any diagnostic testing?

- [ ] X-Rays
- [ ] MRI
- [ ] CT
- [ ] Other

If Other, please list:

When and Where?

Please (X) where you feel pain on figure below: