

C-92 (Permanent/Partial Disability Exam)
INTAKE/DISCHARGE SHEET

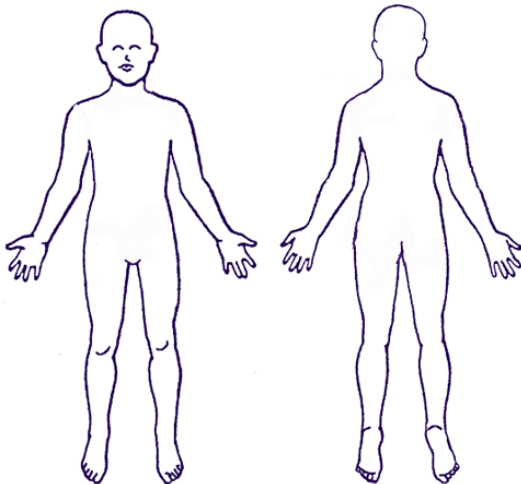
Please Print

Patient Information

Name _____ Date _____
Date of Birth _____ Age _____ Social Security Number _____
Phone # _____ Cell # _____
Street Address _____
City _____ State _____ Zip _____
E-Mail _____
Occupation _____
Employer _____ Business Phone _____
Sex: Male Female Height _____ Weight _____
Are you Married Single Domestic Partnership Divorced Separated Widowed

Medical History

Please indicate on the picture below your problem areas. Please use the following symbols provided:



- = = - Numbness
- OO - Pins and Needles
- XX - Aching
- /// - Stabbing

Pain scale: (1-10 - 1 = low, 10 = High)

Neck: _____
Mid Back: _____
Low Back: _____
Extremities: _____

Patients Signature: _____ Date: _____