

PATIENT INFORMATION

DATE: ____ / ____ / ____ SOCIAL SECURITY # ____ - ____ - ____
PATIENT NAME: _____ E-MAIL: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: ____ - ____ - ____ CELL: ____ - ____ - ____ WORK: ____ - ____ - ____
SEX: ____ M ____ F BIRTH DATE: ____ / ____ / ____ ____ SINGLE ____ MARRIED ____ SEPARATED ____ DIVORCED
____ EMPLOYED ____ STUDENT ____ RETIRED
PATIENT EMPLOYED BY: _____ OCCUPATION: _____
TYPE OF CASE: ____ CASH ____ PERSONAL INSURANCE ____ WORKMAN'S COMP. ____ AUTO ACCIDENT ____ MEDICARE ____ MEDICAID
REFERRED TO THIS OFFICE BY: _____ PRIMARY PHYSICIAN'S NAME: _____
PRIMARY PHYSICIAN'S LOCATION: _____ CLINIC _____ CITY _____
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?: _____ PHONE: _____

ABOUT YOUR CURRENT CONDITION

WHAT IS YOUR CURRENT WEIGHT? _____ LBS. HEIGHT: _____ FT. _____ IN. AGE: _____
PLEASE DESCRIBE YOUR CONDITION: Date Condition Began ____ / ____ / ____ _____

WHAT IS YOUR LEVEL OF PAIN TODAY? (scale of 1 - 10, 10 being severe): _____
IS THIS CONDITION GETTING WORSE? ____ YES ____ NO ____ CONSTANT ____ COMES & GOES
WHAT ACTIVITIES MAKE YOUR PAIN BETTER? _____
WHAT ACTIVITIES MAKE YOUR PAIN WORSE? _____
IS THIS CONDITION INTERFERING WITH YOUR (Please Circle): WORK SLEEP DAILY ROUTINE
IF SO, PLEASE EXPLAIN: _____
HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? ____ YES ____ NO
IF SO, PLEASE EXPLAIN: _____
HAVE YOU BEEN TREATED BY ANY OTHER DOCTOR FOR THIS CONDITION? ____ YES ____ NO
IF SO, WHERE & WHEN: _____
ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?
____ NERVE PILLS ____ PAIN KILLERS (including aspirin) ____ MUSCLE RELAXERS ____ STIMULANTS ____ BLOOD THINNERS
____ TRANQUILIZERS ____ INSULIN ____ OTHER(S): _____
PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD: _____
PLEASE LIST ANYTHING THAT YOU MIGHT BE ALLERGIC TO: _____
LIST PREVIOUS SURGERIES (with dates): _____
LIST ANY PAST SERIOUS ACCIDENTS (with dates): _____

SOCIAL HISTORY

DO YOU: DRINK ALCOHOL? ____ NO ____ YES / HOW MUCH PER WEEK? _____
DO YOU: SMOKE? ____ YES ____ NO EXERCISE? ____ YES ____ NO WEAR SEATBELTS? ____ YES ____ NO
FOR WOMEN: ARE YOU TAKING BIRTH CONTROL? ____ YES ____ NO PAST PREGNANCIES: _____
ARE YOU PREGNANT? ____ NO ____ YES / HOW LONG? _____ NURSING? ____ YES ____ NO

REVIEW OF SYSTEMS

Please check current and past problems.

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies/Sinus Pain | <input type="checkbox"/> Alcoholism/Drug Use |
| <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Ringing in Ears / Dizziness | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fever | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Pain Between Shoulders |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Kidney/Bladder/Prostate Problems | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Shoulder/Hip Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver/Pancreas Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Change in Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Other: _____ |

Comments (CONTRIBUTORY / NON-CONTRIBUTORY):

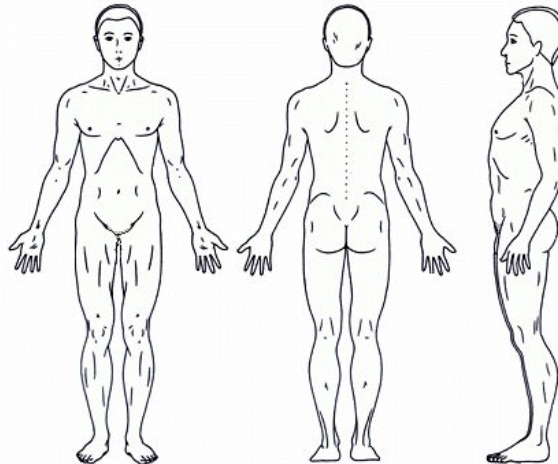
FAMILY HISTORY

FATHER: IS HE LIVING? YES NO CAUSE OF DEATH: _____

MOTHER: IS SHE LIVING? YES NO CAUSE OF DEATH: _____

BROTHERS/SISTERS: HOW MANY? _____ SIGNIFICANT FAMILY HEALTH PROBLEMS: _____

PAIN DIAGRAM – PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT BELOW:



INSURANCE ASSIGNMENT AND RELEASE, AUTHORIZATION AND CONSENT TO TREAT

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. Furthermore, any risks involving treatment will be explained to me upon request. I understand the above information and guarantee this form was correctly completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient or Responsible Party Signature

Relationship to Patient

Date