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 PHYSICAN'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.

___ Headaches
___Numbness / Tingling
___Ringing in Ears / Dizziness
___Loss of Balance
___Chest Pain
___Heart Attacks
___Swollen Ankles
___High/Low Blood Pressure
___Stroke
___Trouble Breathing
___Shortness of Breath
___Asthma

___Allergies/Sinus Pain
___Fatigue
___Night Sweats
___Fever
___Weight Loss
___Cancer
___Kidney/Bladder/Prostate Problems
___Painful Urination
___Liver/Pancreas Problems
___Diabetes
___Constipation/Diarrhea
___Heartburn/Reflux

___Alcoholism/Drug Use
___Ulcer
___Hernia
___Low Back Pain
___Pain Between Shoulders
___Stiff Neck
___TMJ Problems
___Shoulder/Hip Pain
___Depression
___Skin Allergies
___Change in Moles
___Other:____

Comments (CONTRIBUTORY / NON-CONTRIBUTORY):
____
____

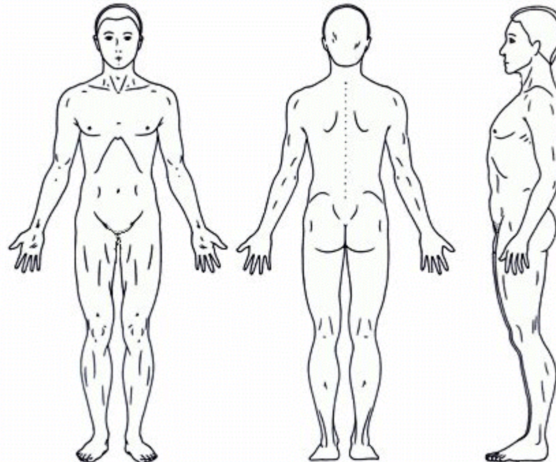
FAMILY HISTORY

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