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	___Allergies/Sinus Pain	___Alcoholism/Drug Use
___Numbness / Tingling	___Fatigue	___Ulcer
___Ringing in Ears / Dizziness	___Night Sweats	___Hernia
___Loss of Balance	___Fever	___Low Back Pain
___Chest Pain	___Weight Loss	___Pain Between Shoulders
___Heart Attacks	___Cancer	___Stiff Neck
___Swollen Ankles	___Kidney/Bladder/Prostate Problems	___TMJ Problems
___High/Low Blood Pressure	___Painful Urination	___Shoulder/Hip Pain
___Stroke	___Liver/Pancreas Problems	___Depression
___Trouble Breathing	___Diabetes	___Skin Allergies
___Shortness of Breath	___Constipation/Diarrhea	___Change in Moles
___Asthma	___Heartburn/Reflux	___Other:_____

Comments (CONTRIBUTORY / NON-CONTRIBUTORY):

_____

_____

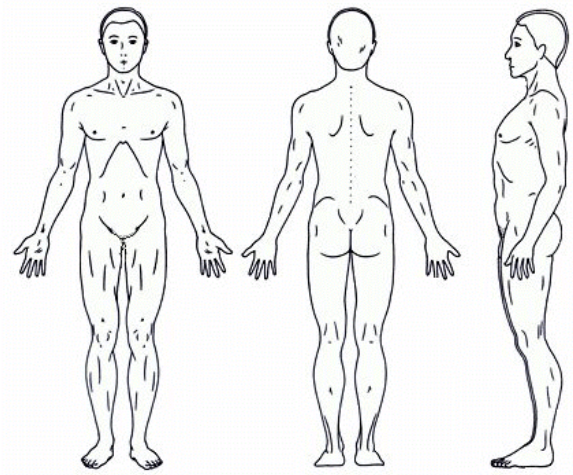
FAMILY HISTORY

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