

PATIENT INFOName: _____
(LAST) (MI) (FIRST)Address: _____
(STREET) (CITY) (STATE) (ZIP)

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

Email Address: _____

DOB: ____ / ____ / ____ Soc. Sec #: ____ - ____ - ____

Driver's License #: _____ State: _____

Marital Status: S M W Spouse's Name: _____

Your Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____ Primary Care Physician: _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (If Different From Patient): _____ Relationship to Patient: _____

Insurer's DOB: ____ / ____ / ____ Insurer's Soc. Sec #: ____ - ____ - ____

Insurer's Employer: _____

Person responsible for account: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature

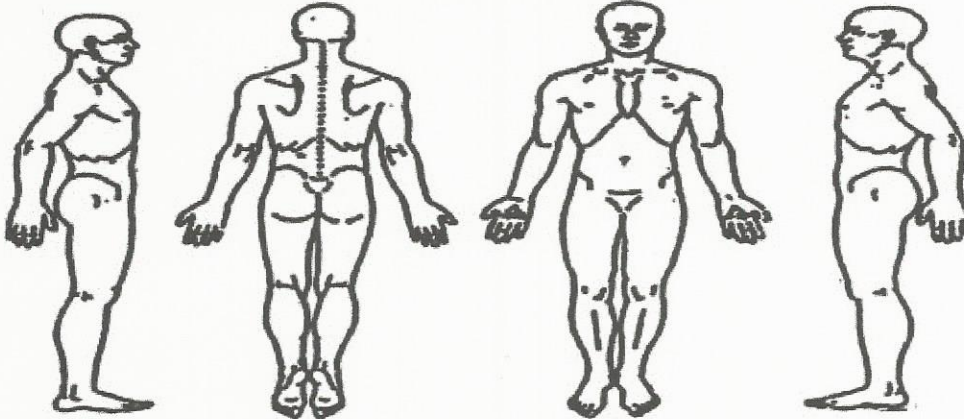
Date:

Patient Name: _____ Date: _____

1. Today's problem will be filed as: Insurance/ Self Pay Auto Accident Workman's Compensation

2. What is your primary area of concern/ pain? _____

3. Indicate on the drawings below where you have pain/symptoms:



4. How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric-like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the Time) | <input type="checkbox"/> Occasionally (26-50% of the Time) |
| <input type="checkbox"/> Frequently (51-75% of the Time) | <input type="checkbox"/> Intermittently (1-25% of the Time) |

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

- | | | |
|--|---|---|
| <input type="checkbox"/> Getting worse | <input type="checkbox"/> Staying the same | <input type="checkbox"/> Getting better |
|--|---|---|

12. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

13. How would you rate your overall health?

- Excellent Very Good Good Fair Poor

14. Rate your level of exercise activity:

- Strenuous Moderate Light None

15. Indicate if you suffer from or have immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

16. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	Females Only	
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

17. List all prescription and over-the-counter medications you are currently taking:

18. List all nutritional supplements you are currently taking:

19. List all surgical procedures you have undergone:

20. What activities do you do at work?

Sit

Most of the day

Half of the day

A little of the day

Stand

Most of the day

Half of the day

A little of the day

Computer Work

Most of the day

Half of the day

A little of the day

On the Phone

Most of the day

Half of the day

A little of the day

Drive

Most of the day

Half of the day

A little of the day

Other Activities

Perform manual labor

Read a lot

Travel frequently

21. What activities do you enjoy outside of work?

22. Have you ever been hospitalized? Yes No

If yes, why? _____

23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? Yes No

If yes, what and when? _____

24. Is there anything else you wish to let the doctor know about your visit today? Yes No

If yes, what? _____

Patient Signature _____ **Date** _____