1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ Date ______ Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____) ______ Home Phone (____) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ______

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

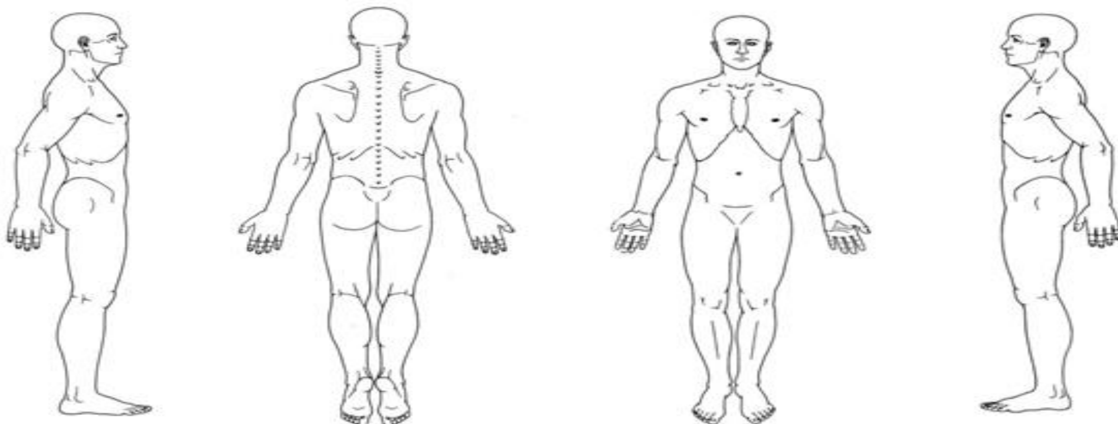
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______

Name:	**Date of Birth: / /**
Physical Address:	**Telephone Number:**
City/State/Zip	**Cell Number:**
What brings you in to the clinic today (chief complaint)?	

How long has this been going on? _____________
Frequency: Constant or Comes and Goes
In the last 6 months, the pain is: Same Better Worse

Area of Pain/Numbness/Injury: Please Circle area of concern.



Symptoms:

Y	N	Symptom	Y	N	Symptom
Y	N	Joint Redness	Y	N	Numbness/Tingling: Hands Feet Legs Arms
Y	N	Joint Swelling	Y	N	Throbbing: Hands Feet Legs Arms
Y	N	Joint Tenderness	Y	N	Aching: Hands Feet Legs Arms
Y	N	Joint Warmth	Y	N	Burning: Hands Feet Legs Arms
Y	N	Limping	Y	N	Stabbing: Hands Feet Legs Arms
Y	N	Locking of the Joint	Y	N	Shooting: Hands Feet Legs Arms
Y	N	Loss of Range of Motion: Joint	Y	N	Pins/Needles: Hands Feet Legs Arms
Y	N	Inflexibility	Y	N	Pulsating: Hands Feet Legs Arms
Y	N	Balance Issues	Y	N	Deadness: Hands Feet Legs Arms
Y	N	Difficulty Standing	Y	N	Dull: Hands Feet Legs Arms
Y	N	Difficulty sitting to standing	Y	N	Stinging: Hands Feet Legs Arms
Y	N	Difficulty climbing stairs	Y	N	Pounding: Hands Feet Legs Arms
Y	N	Difficulty laying down	Y	N	Cramps: Hands Feet Legs Arms
Other Symptoms not mentioned:			Y	N	Stiffness: Hands Feet Legs Arms
			Y	N	Spasms: Hands Feet Legs Arms
			Y	N	Cold: Hands Feet Legs Arms

Allergies: (please list all)

☐ No Known Drug Allergy	☐ Yes:
☐ No Known Food Allergy	☐ Yes:
☐ Other Allergies:	☐ Yes:

Patient Name: ____ Date: _________________

History of Present Illness

How long has this been going on? ______ **Is it:** Constant or Comes and Goes

Subjective Progression over last 6 months: Better Same Worse

Does pain radiate or travel? ☐Yes ☐ No

If Yes, where to?

Pain and Numbness Scale 0-10

(0 no pain or numbness, 10 being the worst pain/worst numbness).

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Numbness 0 1 2 3 4 5 6 7 8 9 10

What makes pain or numbness better? ☐ Rest ☐ Walking ☐ Pain medicines
☐ Other (specify):

What makes the pain worse? ☐ Rest ☐ Walking ☐ Pain medicines
☐ Other (specify):

Is the pain: ☐ Constant ☐ Intermittent ☐ Worse at night

Have you considered surgery? ☐ Yes ☐ No

Have you had previous treatment or surgery? ☐ Yes ☐ No

Have you had any Nerve testing, EMG? ☐ Yes, when ________ ☐ No

If yes, what treatment or surgery?

Any Xray, CT, MRI? If yes, when:

Results stated:

Daily Activity Impairment

Circle the number that indicates how you feel on a daily basis

0=no difficulties 5=moderate difficulty 10=severe or unable to perform

Activity											
Walking	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Climbing Stairs	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
Household Chores	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Yardwork	0	1	2	3	4	5	6	7	8	9	10
Sports	0	1	2	3	4	5	6	7	8	9	10
Gardening	0	1	2	3	4	5	6	7	8	9	10
Shopping	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Personal Care	0	1	2	3	4	5	6	7	8	9	10

Patient Name: ____ Date: _______________

Past Medical Health History					
Y N	Blood Thinners: ☐ Current ☐ Past	Y N	Blood clots: ☐ Legs ☐ Lungs	Y N	Vitamin deficiency: ☐ B12 ☐ D3
Y N	Anesthesia Problems	Y N	Heart Disease	Y N	Hernia
Y N	Anemia	Y N	High Cholesterol	Y N	Hepatitis
Y N	Depression	Y N	High Blood Pressure	Y N	Sciatica: R L Both
Y N	Anxiety	Y N	Chest Pain	Y N	Gout
Y N	Arthritis	Y N	Lung Disease	Y N	Stroke/ TIA
Y N	Sleep Apnea	Y N	COPD	Y N	Chest pain
Y N	Epilepsy	Y N	Emphysema	Y N	Hernia:
Y N	Fibromyalgia	Y N	Thyroid Problems	Y N	Lower Back Pain
Y N	Polio	Y N	HIV	Y N	Spinal Fractures
Y N	Neuropathy	Y N	Kidney Disease	Y N	Disc: ☐ Herniation ☐ Bulge
Y N	Diabetes Type 1	Y N	Liver Disease	Y N	
Y N	Diabetes Type 2	Y N	GERDS	Y N	Spinal stenosis
Y N	Ulcers	Y N	MRSA	Y N	Spinal arthritis
Y N	Vascular Surgery	Y N	Shingles	Y N	Degenerative Disc
Y N	Spider Veins	Y N	Weakness	Y N	Fusion:
Y N	Varicose Veins	Y N	Plantar Fasciitis	Y N	Joint Replacement
Y N	Lupus	Y N	Chemical Exposure: ☐ Pesticides ☐ Agent Orange		
Y N	CANCER: Location: ___________________________ YEAR: ______________ ☐ Y ☐ N Chemotherapy ☐ Y ☐ N Radiation ☐ Y ☐ N Medication Type:____				
Y N	Pregnant or Breast Feeding				
Other:					

Past Surgical History: Or see attached form	
Surgery	***Date***
Laminectomy: Specific Level	
Spinal Fusion: Specific Level	
Heart:	
Appendectomy:	
Gall bladder:	
Colon:	
Stomach:	
Joint Replacement:	
Arthroscopy:	

Patient Name: ____ Date: ________________

Social History	
Tobacco	☐ Pack per day: ___ ☐ Occasional ☐ Never ☐ Quit: year
Chewing Tobacco	☐ Daily ☐ Weekly ☐ Occasional ☐ Never ☐ Quit: year
Alcohol	☐ Daily ☐ Weekly ☐ Occasional ☐ Never ☐ Quit: year
Recreational Drugs	☐ Daily ☐ Weekly ☐ Occasional ☐ Never ☐ Quit: year
Exercise	☐ Daily ☐ Weekly ☐ Occasional ☐ Never ☐ How often?

Family History

Mother: ☐ Living ☐ Deceased: Cause of Death:___________________________________
Relevant Health History:____

Father: ☐ Living ☐ Deceased: Cause of Death: ___________________________________
Relevant Health History:

Notes:

Review of Systems: Please circle Y=yes, if you have or had. N= no.

Constitutional		**Respiratory**		**Cardiovascular**	
Recent Weight: ☐ Gain ☐ Loss	Y N	Cough: ☐ Recurrent ☐ Chronic	Y N	Palpations	Y N
Fever	Y N	Pneumonia	Y N	Swelling Feet/Ankles	Y N
Skin	Y N	Tuberculosis	Y N	Pounding Heart	Y N
Discoloration	Y N	**Gastrointestinal**	Y N	Low blood pressure	Y N
Pigment Changes	Y N	Nausea	Y N	**Extremities**	Y N
Neurologic	Y N	Abdominal pain	Y N	Cold	Y N
Migraines	Y N	Constipation	Y N	Numbness	Y N
Headaches	Y N	Diarrhea	Y N	Tingling	Y N
Dizziness	Y N	GI disturbance	Y N	Pain	Y N

Medication and/or Supplements or See list Attached

Name	Dosage	Name	Dosage

____