

WELCOME TO OUR PRACTICE

To insure proper case information, please provide us with the following information.
If you need assistance in completing these forms, please step to the front desk.

Today's date _____

Name _____ Nick-name preferred: _____

Date of Birth _____ Male Female Soc.Sec # _____

Mailing Address _____

City, State, Zip _____ Home Phone _____

Occupation _____ Email _____

Employer _____ Work Phone _____

Employer's Address : _____ Cell Phone _____

City, St, Zip _____

Were you referred by Yourself Friend Insurance Carrier Primary physician Other physician

Name of person who referred you: _____

If different from above, who is your family physician? _____ Phone # _____

IF WE HAVE COPIES OF YOUR INSURANCE CARDS YOU MAY SKIP THIS SECTION

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Signature

Date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: Suddenly Built up over several days Gradually worse over a long time.
If you were injured was it: At Work At Home Due to Auto Accident Other Injury

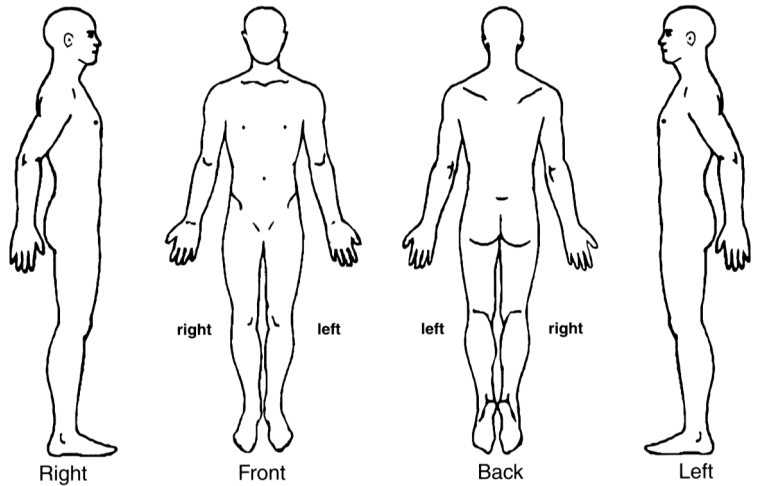
ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++ Burning /// Stabbing
... Pins & needles xxx No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent

AREA 2 pain is (1-10) ___ Constant or Intermittent



Please help us understand your pain: Circle the words for each area that best describes your pain and activity during your day.

Area 1 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace Walker Cane Crutches Wheelchair

Please help us better understand your personal circumstances and assist us in providing you customized treatment and care.

I Am Working Full Time Part Time Homemaker Full Time Student Unemployed Retired

Now: Occupation: _____

On sick leave On Temp disability On Full Disability My last day worked was _____

Age _____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now Smoke ___ Packs per day Stopped _____ Use Alcohol Type and Amt _____

Consume Caffeine: Type/ Amt _____ Use recreational drugs _____

I am now or have in the past been : Addicted to drugs alcohol Treated for alcohol or drug addiction

WOMEN ONLY Can you become pregnant? YES NO Date of last period _____ Normal Yes No

If not, why? _____ Date of last Mammogram _____ Normal Yes No

Are you now or could you be pregnant ?? YES NO Pap Smear _____ Normal Yes No

Patient Primary Intake History

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease / Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS / Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Rheumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis / Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (Prescription and over the counter)	HOSPITALIZATION and SURGERY																		
<p>Name of medication and Strength # of doses / day</p> <table border="1"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>													<p>PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)</p> <table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>						

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

condition	who?	condition	who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X	Primary Intake History #6011
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