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CONFIDENTIAL PATIENT INFORMATION

These forms are legal documents and are necessary to bill insurance and are a part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

GENERAL INFORMATION

Date:
First Name M.I. Last Name
Address City State Zip
Home Phone Work Phone Cell Phone
Gender: Male Female Marital Status: S M D W Number of Children
Date of Birth Age Email Address
Driver License # Social Security #
Employer Name Occupation
Address of Employer City State Zip
Name of spouse Spouse's Employer
Person Responsible for this Account Health Plan
Subscriber Name DOB ID #

Is the condition you are here for the result of a work related injury? YES NO (Circle one)
(if YES, have you reported it to your supervisor?) YES NO (Circle one)

Is the condition you are here for the result of an automobile collision? YES NO (Circle one)

How do you intend to pay for today's visit?

Do you have health insurance? YES NO Insurance Company
(if YES, please provide the receptionist with a copy of your insurance card.)

Name of policy holder
Relationship: Self Spouse Parent Other

How did you hear about our office?

"I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand that I am responsible for the payment of all services rendered to me if my insurance, for whatever reason, does not pay for services rendered to me. I also understand that if I terminate my care, any fees for professional services rendered me will become due and payable."

Patient/Parent/or Guardian Signature

Date

PATIENT SYMPTOMS AND HISTORY

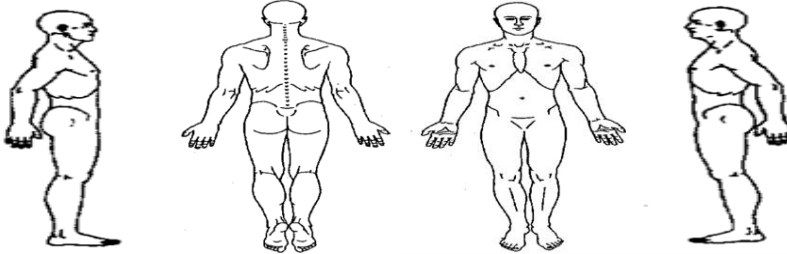
Patient Name: _____ Date: _____

1. Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

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



3. How often do you experience symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)

- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

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

5. How are your symptoms changing with time?

- Getting worse
- Not changing
- Getting better

6. Using a scale from 0 – 10 (10 being the worst), how would you rate your problem?

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

7. How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

8. How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

9. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No-one |

a. What treatment did you receive and when? _____

b. Were any tests performed for your symptoms?

1) X-ray date _____ 3) CT scan date _____

2) MRI date _____ 4) Other date _____

10. Do you consider this problem to be severe?

- Yes
- Yes, at times
- No

11. What aggravates your problem? _____

12. What makes your problem better? _____

13. What concerns you the most about your problem; what does it prevent you from doing? _____

14. Have you had similar symptoms in the past?

- Yes
- No

a. What treatment did you receive:

- | | | |
|---------------------------------------|---|--------------------------------|
| <input type="checkbox"/> This office | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Physical Therapist | |

15. How would you rate your overall health?

