Patient Information

Date: ___/___/_______ SS#/HIC/Patient ID: ______________________ Sex: Male Female

Name- Last: ______________________ First: _______________________ Middle Initial: ______

Address: ____

City: _________________ State: _____ Zip: _________ Email: ___________________________

Spouse's Name: _______________________ Home Phone: _______________ Work: ___________

Date of Birth: ___/___/______ Status: Student Employed Self-employed Retired

Employer/School: _________________________ Address: _______________________________

Employer/School Phone: _________________________ Type of work: _____________________

Referred by: _________________________________

Insurance Information

Who is responsible for this account: ____

Relationship to patient: ____

Insurance Company: ___________________________________ Group #: ___________________

If other than patient-

Insurance Company: ___________________________________ Group #: ___________________

Subscriber Name: Last: ______________________ First: ____________________Middle: _____

Subscriber Date of Birth: ___/___/______ SS#/HIC/ID: ___________________________

If coverage by any other insurance-

Insurance Company: ___________________________________ Group #: ___________________

Subscriber Name: Last: ______________________ First: ____________________Middle: _____

Subscriber Date of Birth: ___/___/______ SS#/HIC/ID: ___________________________

Assignment and Release – I certify that I and/or my dependent(s) have insurance coverage as shown above and hereby assign directly to ___________________________________ 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. I also authorize the release of my/my dependent(s) health care information to the above named insurance company(s) and their agents for the purpose of determining benefits and obtaining payment for services. This consent will end when the treatment plan is completed or one year from the date signed below.

___________________________Signature of Patient, Parent, Guardian or Personal Representative

___________________________Print name of Patient, Parent, Guardian or Personal Representative

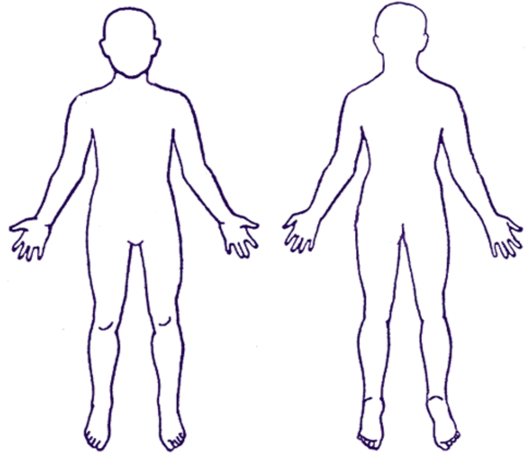
___/___/______ Date of signature ________________________________ Relationship to patient

Patient Condition

Reason for this visit: ____

When did symptoms appeared: ___/___/______ Time: ______ Are they getting worse? No Yes Don't know

On the diagrams to the right, mark the location(s) where the pain/numbness/tingling is located:



Circle word(s) describing your pain/numbness/tingling:

Mild Moderate Severe Sharp Dull Shooting

Burning Tingling Stiff Continual Intermittent

Other (explain:)_________________________

____

____

Does it interfere with: Work Sleep Daily Routine Recreation Sitting Standing Walking Bending Lying Down

What treatment have you already received: ____

____

Where: ____

By Whom? ____

Patient History (please circle answers and fill blanks)

1. Do you have any Allergies: NO YES

   Please list: ____

2. Do you suffer from Headaches: NO YES

   If YES, please circle: Frontal Temporal Migrane Sinus After reading Periodic

3. Do you have Respiratory Problems: NO YES

   If YES, please circle: Emphysema Asthma Tuberculosis Shortness of breath Cough

4. Do you have any Circulatory Problems: NO YES

   If YES, please circle: Blood pressure Stroke Heart attack or angina Murmur Irregular beat

   Cold extremeties Blood thinners Pacemaker/defibrillator Other

   Explain: ____

____

____

5. Have you now, or have you had any dis-function of your Kidneys, Stomach, Liver or Gallbladder? NO YES

   If YES, please explain: ____

____

____

6. Hormonal Problems: NO YES

   If YES, please circle which and explain: Thyroid Diabetes Other – please explain:

____

Patient History (continued)

7. Are you on Birth Control: NO YES

What method/product? ____________________

8. Skeletal/Muscular Problems: NO YES

Arthritis Joint pain Muscle disease Orthopedic/Neurological Surgery Osteoporosis

Curvature Scoliosis Fracture Other defect: ____________________

Fractures – list and how treated: ____________________

List surgeries: ____________________

List pins/rods/screws/plates/other implants: ____________________

Location(s)/date(s) of implants: ____________________

9. Have you ever had an x-ray, CT scan, or MRI? NO YES

If YES, for what reason(s)? ____________________

Was Lab Work done in conjunction with the x-ray, CT scan, or MRI? NO YES

If YES, list abnormal findings: ____________________

10. Have you ever been diagnosed with Degeneration of Bony Tissues? NO YES

11. Has a health care provider ever advised you against a procedure? NO YES

If YES, explain: ____________________

____

12. List any other Medical Procedure(s) or Physical Therapy(s) you have had along with the date:

____

____

13. List any good result(s) from a procedure/therapy: ____________________

14. List any bad result(s) from a procedure/therapy: ____________________

Have you now, or have you had nerve pain and/or numbness? NO YES

If YES, explain: ____________________

____

15. Have you now, or have you had a medical condition you would like to discuss with the doctor?

NO YES If YES, explain: ____________________

____

16. List all medications/drugs you are taking: ____________________

17. Are you pregnant? NO YES

18. Can you smile, frown, wink either eye? NO YES

19. Do any health problems run in your family? NO YES

If YES, explain: ____________________

____

20. Is there anything additional you would like to discuss with the doctor? NO YES

If YES, explain: ____________________

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