



Patient Information

Date: \_\_\_/\_\_\_/\_\_\_ Phone # \_\_\_-\_\_\_-\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Social Security Number: \_\_\_-\_\_\_-\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Separated [ ] Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_-\_\_\_-\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Spouse/Partner Date of Birth: \_\_\_/\_\_\_/\_\_\_

Spouse/Partner Phone: \_\_\_-\_\_\_-\_\_\_ Spouse/Partner SS #: \_\_\_-\_\_\_-\_\_\_

Spouse/Partner Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Insurance Information (please provide copy of card to receptionist)

Responsible party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_-\_\_\_-\_\_\_

Is the patient covered by additional insurance? [ ] Yes [ ] No

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_

RELEASE

I, the undersigned, authorize the Dr. and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Responsible Party Signature Relationship to Patient

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Date

**Patient Condition**

Reason for Visit:

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When did your symptoms first appear?

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Is your pain:  Mild  Moderate  
 Severe

On a scale of 1 to 10, 10 being the worst, what is the severity of your pain: \_\_\_\_\_

Type of pain:  Sharp  Dull  
 Throbbing  Numbness  
 Aching  Shooting  
 Burning  Tingling  
 Cramps  Stiffness  
 Swelling  
 Other

Since the onset of symptoms, they have gotten:  
 Same  Better  Worse

Does it interfere with:  Work  Sleep  
 Daily Routine  
 Recreation

How does it interfere? \_\_\_\_\_  
\_\_\_\_\_

Activities/movements that are painful to perform:

Sitting  Standing  Walking  
 Bending  Lying down

Exercise:  None  Moderate  
 Daily  Heavy

Is this condition due to an accident?

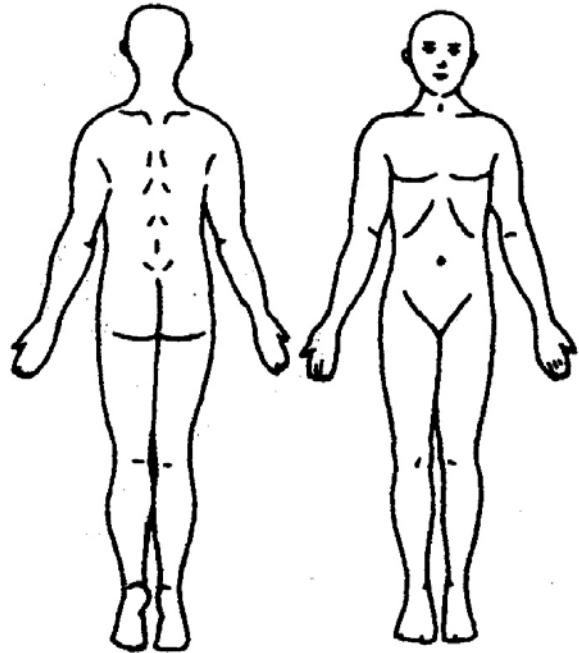
Y  N

Type of accident:  Auto  Work  
 Home  Other

To whom have you reported the accident?

Auto Insurance  Employer  Other

**Mark an "X" on the picture where you have pain, numbness, or tingling:**



Medications:

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## CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

**An understanding of your health history will help us to determine appropriate care.**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
AGE \_\_\_\_\_ RACE \_\_\_\_\_ GENDER \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

### Review of Systems

1. Do you have skin, hair or nail problems? [ ]Yes [ ]No \_\_\_\_\_
2. Do have mouth and/or throat problems? [ ]Yes [ ]No \_\_\_\_\_
3. Do you have nose and/or sinus problems? [ ]Yes [ ]No \_\_\_\_\_
4. Do you have ear problems? [ ]Yes [ ]No \_\_\_\_\_
5. Do you have eye problems? [ ]Yes [ ]No \_\_\_\_\_
6. Do you have chest or lung (breathing) problems?[ ]Yes [ ]No \_\_\_\_\_
7. Do you smoke? [ ]Yes [ ]No Packs/Day \_\_\_\_\_
8. Do you have heart and/or blood vessel problems? [ ]Yes [ ]No \_\_\_\_\_
9. Do you have blood or lymph node problems? [ ]Yes [ ]No \_\_\_\_\_
10. Do you have digestive problems? [ ]Yes [ ]No \_\_\_\_\_
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? [ ]Yes [ ]No \_\_\_\_\_
12. Do you have urinary (including kidney or bladder) problems? [ ]Yes [ ]No \_\_\_\_\_
13. Do you have any nervous system diseases and/or mental health problems?  
[ ]Yes [ ]No \_\_\_\_\_
14. Do you have any gland and/or hormone problems? [ ]Yes [ ]No \_\_\_\_\_
15. Do you have allergy or immunity problems? [ ]Yes [ ]No \_\_\_\_\_
16. Do you have any muscle, tendon or ligament problems? [ ]Yes [ ]No \_\_\_\_\_
17. Do you have any bone or joint diseases (examples: bone=osteoporosis, joint=arthritis)?
18. [ ]Yes [ ]No \_\_\_\_\_

### Past History

19. List any diseases that you have had in the past, including childhood diseases:  
\_\_\_\_\_
20. Tell us if you have every been diagnoses as having a particular condition, such as diabetes, cancer, AIDS ,etc.:  
\_\_\_\_\_
21. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?  
[ ]Yes [ ]No \_\_\_\_\_
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

**CASE HISTORY  
(CONTINUED)**

23. Have you every been hospitalized for any reason other than surgery?  Yes  No  
24. Your diet is:  Balanced  Fair  Poor  Excessive  Restricted

**Family History**

25. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases or conditions)?  Yes  No

**Social History**

26. In what position do you usually sleep, and how well? \_\_\_\_\_  
27. Do you exercise on a regular basis?  Yes  No How? \_\_\_\_\_  
28. How do you spend your spare time (hobbies, etc.)? \_\_\_\_\_  
29. Do you use:  Caffeine  Tobacco  Nicotine  Recreational Drugs  Alcohol  
30. Please describe your work:  
Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker  
Physical Demands:  Heavy  Moderate  Mild  Sedentary  
Stress Level:  High  Medium  Low

**Additional Questions**

31. Do you have problems with recurring headaches?  Yes  No  
32. Are you losing weight without trying?  Yes  No  
33. Does your pain wake you up at night?  Yes  No  
34. Have you had a change in bowel or bladder habits?  Yes  No  
35. Have you had a sore that doesn't heal?  Yes  No  
36. Have you recently had any unusual bleeding or discharge?  Yes  No  
37. Do you have a thickening/lump in the breast or elsewhere?  Yes  No  
38. Do you have indigestion or difficulty swallowing?  Yes  No  
39. Have you had an obvious change in a wart or mole?  Yes  No  
40. Do you have a nagging cough or hoarseness?  Yes  No  
  
41. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history that was not requested, please fill it in below:

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42. Who is your:  
Medical Doctor: \_\_\_\_\_  
OB/GYN: \_\_\_\_\_  
Dentist: \_\_\_\_\_