CONFIDENTIAL PATIENT INFORMATION

WELCOME!

Name: ______________________________ Date: ______________

Address: ____
Street Address/P.O. Box *City* *State* *Zip*

Home Phone #:__________ Work Phone #:__________ E-mail Address: ______________

❒ Male ❒ Female Date of Birth: ____/____/____ Age: _______ Height: ________ Weight: _________ SSN: ___________

Marital Status: ❒ *Single* ❒ *Married* ❒ *Divorced* ❒ *Widowed* ❒ *Separated* ❒ *Children: # of* __________

Education: *# of years completed:* _______ ❒ *Full-time student* ❒ *Part-time student* ❒ *Non-student*

Employed: ❒ *Full-time* ❒ *Part-time*

Work Status: ❒ *Working without restrictions* ❒ *Working with restrictions* ❒ *Not working/off work since*________________ ❒ *Retired*

Employer: ______________________________ Occupation: ______________

Job Description: ______________________________ Years Employed: ______________

Address: ____
Street Address/P.O. Box *City* *State* *Zip*

____

Date of injury, surgery, or onset of symptoms:_________________

What type of injury are we seeing you for?
❒ *Auto* ❒ *Sports Injury* ❒ *No specific trauma*
❒ *Work* ❒ *Slip & Fall* ❒ *Other*

Emergency Contact, not living with you:

Name: ______________________________

Phone #:____________ Relationship: ______________

✓

PATIENT'S AUTO/WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Company:______________________________ Phone: ______________

Billing Address: ____
Street Address/P.O. Box *City* *State* *Zip*

Claim #: ______________________ Group/Policy #: ______________________

Adjuster's Name: ______________ Adjuster's Phone #:______________ Adjuster's Fax #:______________

Insured's Name: ______________ SSN of Insured:______________ Relationship to Patient:______________

Address of Insured: ____
Street Address/P.O. Box *City* *State* *Zip*

✓

PATIENT'S HEALTH INSURANCE INFORMATION

Insurance Company:______________________________ Phone: ______________

Billing Address: ____
Street Address/P.O. Box *City* *State* *Zip*

Claim #: ______________________ Group/Policy #: ______________________

Adjuster's Name: ______________ Adjuster's Phone #:______________ Adjuster's Fax #:______________

Insured's Name: ______________ SSN of Insured:______________ Relationship to Patient:______________

Address of Insured: ____
Street Address/P.O. Box *City* *State* *Zip*

I hereby consent to and authorize all treatment that may be advisable or necessary. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR SERVICES PROVIDED REGARDLESS OF MY INSURANCE STATUS. I will inform this office of any changes in medical history, insurance coverage, telephone and/or address changes as they occur. I certify this information is true and correct to the best of my knowledge. I hereby authorize and give specific Power of Attorney to Advanced Spine & Rehabilitation to endorse my name to any and all checks, drafts or money orders which are made payable to the undersigned and/or Advanced Spine & Rehabilitation, which are paid by my insurance company for services rendered to me.

Payment is expected at time of service for "Your Portion" of charges. We accept VISA/MASTERCARD for your convenience. There will be a charge of $25 for all returned checks. If copies or records are requested, there is a charge of $.60 per page.

In the event your account becomes past due, it may accrue interest at the rate of 1.5% per month (18% per annum). Your account may be referred to a Collection Agency for nonpayment. Interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all collection costs, attorney fees, court costs, service fees, and miscellaneous fees/costs (which could double the outstanding balance). Further, your signature authorizes Advanced Spine & Rehabilitation to release any medical information necessary to process your insurance claim. Your signature below indicates that you understand and accept these policies.

______________________________ ______ ______________________________

Signature of Patient (Guardian, if Minor) Date Signature of Witness Date

PATIENT PAIN PROFILE

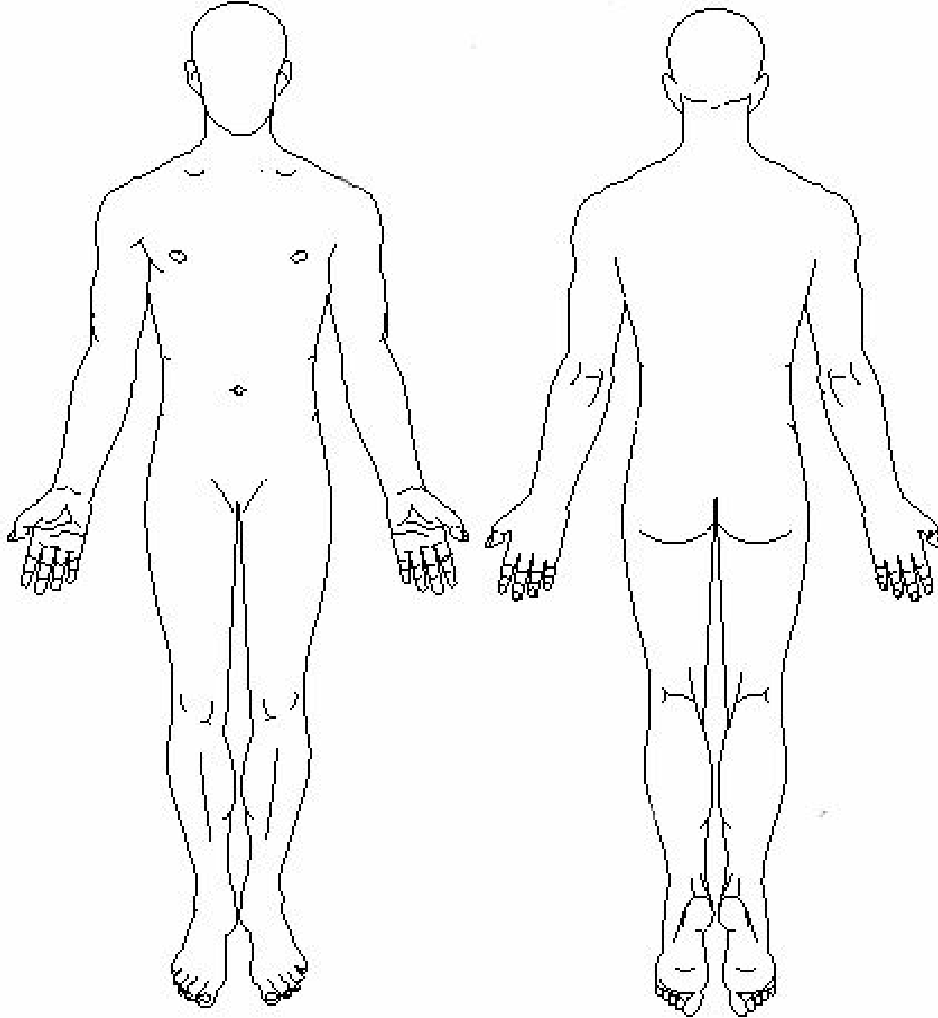
Patient Name: ____ **Date:** __________________________________

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

<u>KEY</u>

A = ACHE N = NUMBNESS P = PINS & NEEDLES B = BURNING S = STABBING

O = OTHER (Please describe):____



What percent of the time is your pain present? If your pain is there all the time, in varying degrees, that would indicate 100%.

Rate the intensity of your pain. Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you cannot perform or complete your work, social, or recreational activities.

	Symptom Description *Describe each symptom, including area, as clearly as possible.*	**Frequency** *Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours*	**Intensity Range** *Using a scale of 0-10, where 10 is the <u>worst</u> pain imaginable, rate the pain intensity level for each symptom.*
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

Patient Name: ____ **Date:**__________________________

REVIEW OF SYSTEMS

Please Mark "No" or "Yes" For Each Symptom

Constitutional	**No**	**Yes**
Excessive Thirst	O	O
Chills	O	O
Convulsions	O	O
Dizziness	O	O
Fainting	O	O
Fatigue	O	O
Fever	O	O
Weight Loss	O	O
Loss of Sleep	O	O
Night Sweats	O	O

Psychiatric	**No**	**Yes**
Nervousness	O	O
Depression	O	O
Mood Swings	O	O

Musculoskeletal	**No**	**Yes**
Arthritis	O	O
Bursitis	O	O
Foot Trouble	O	O
Hernia	O	O
Neck Pain	O	O
Mid Back Pain	O	O
Low Back Pain	O	O
Fractures	O	O

Cardiovascular	**No**	**Yes**
Hardening of Arteries	O	O
High Blood Pressure	O	O
Low Blood Pressure	O	O
Chest Pain	O	O
Poor Circulation	O	O
Rapid Heartbeat	O	O
Slow Heartbeat	O	O
Swelling of Ankles	O	O
Other:	O	O

Respiratory	**No**	**Yes**
Chest Pain	O	O
Chronic Cough	O	O
Difficulty Breathing	O	O
Spitting Up Blood	O	O
Spitting Up Phlegm	O	O
Wheezing	O	O
Asthma	O	O

Gastrointestinal	**No**	**Yes**
Excessive Belching	O	O
Excessive Gas	O	O
Colitis	O	O
Colon Trouble	O	O
Constipation	O	O
Diarrhea	O	O
Difficult Digestion	O	O
Bloated Abdomen	O	O
Excessive Hunger	O	O
Gallbladder Trouble	O	O
Hemorrhoids	O	O
Intestinal Worms	O	O
Jaundice	O	O
Liver Trouble	O	O
Nausea	O	O
Stomach Pain	O	O
Poor Appetite	O	O
Vomiting	O	O
Vomiting of Blood	O	O

Skin	**No**	**Yes**
Bruise Easily	O	O
Dryness	O	O
Hives / Allergy	O	O
Itching	O	O
Varicose Veins	O	O
Skin Eruptions (Rash)	O	O

Eye	**No**	**Yes**
Eye Pain	O	O
Failing Vision	O	O
Far Sighted	O	O
Near Sighted	O	O
Glaucoma	O	O
Blurred Vision	O	O

Ears, Nose & Throat	**No**	**Yes**
Ringing in Ears	O	O
Colds	O	O
Deafness	O	O
Earaches	O	O
Ear Discharge	O	O
Ear Noise	O	O
Enlarged Glands	O	O
Enlarged Thyroid	O	O
Gum Trouble	O	O
Hay Fever	O	O
Hoarseness	O	O
Nasal Obstruction	O	O
Nose Bleeds	O	O
Sinus Infections	O	O
Sore Throat	O	O

Genitourinary	**No**	**Yes**
Blood in Urine	O	O
Frequent Urination	O	O
Kidney Infection	O	O
Painful Urination	O	O
Prostate Trouble	O	O
Seizures	O	O
Are You Pregnant?	O	O

Neurological	**No**	**Yes**
Tremors	O	O
Fainting Spells	O	O
Coordination Difficulty	O	O

SURGERIES / OPERATIONS

	YEAR	**BODY REGION**	**PROCEDURE**
1.			
2.			
3.			
4.			
5.			
6.			

FAMILY HISTORY

Please mark relative's current age or age at time of death.
Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (Describe)	
Father																			
Mother																			
Brothers & Sisters #1																			
#2																			
#3																			
#4																			
#5																			

PRIOR AUTO ACCIDENTS / WORK INJURIES

	YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT
1.				
2.				
3.				
4.				
5.				
6.				

MEDICAL ILLNESSES

List current and past illnesses not mentioned above, including cancer, diabetes, depression, thyroid, heart disease, blood pressure, etc.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

PRIMARY CARE PHYSICIAN

NAME: ____ LAST PHYSICAL EXAM: ____

Patient Name: ______________________________ **Date**: ____________________

HABITS:

	Yes	No	*If yes, please describe*:
Smoking	❒	❒	*Packs per day:* ❒ *½* ❒ *1* ❒ *2 or more* *How long?* __________
Alcohol Consumption	❒	❒	*# Drinks per day* __________ *or # Drinks per week* __________
Other Drug Use (Street Drugs)	❒	❒	____________________
Exercise	❒	❒	❒ *Daily* ❒ *Weekly* ❒ *Monthly* *Type* __________

HANDEDNESS: ❒ Right-handed ❒ Left-handed ❒ Ambidextrous

MEDICATIONS:

Please list all currently used medications. Include prescription and non-prescription drugs.

____
____
____
____
____
____
____

ALLERGIES:

Please list all known allergies, especially to medications.

____
____

TREATMENT YOU ARE RECEIVING OR HAVE RECEIVED FOR THIS CONDITION:

❒ *Medical care* ____________________

❒ *Chiropractic care* ____________________

❒ *Physical Therapy* ____________________

❒ *Other* ____________________

❒ *Other* ____________________

DOCTOR'S NOTES:

____
____
____
____
____

Patient Name: ______________________________ **Date:** ____________________

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Date of Accident: ______________________________

Location of Accident: ______________________________

Questions about the accident circumstances

Year and Make of vehicle you were riding in: ____________________

Number of other vehicles involved ____________________

Year and Make of other vehicle(s):

Vehicle #2 ______________________________

Vehicle #3 ______________________________

Monetary damage to your vehicle: $ ____________________

Was there damage to other vehicles? ____________________

Your head rest was adjusted to:

Top of Shoulder: ____________________

Top of Ear: ____________________

Top of Head: ____________________

Were you the driver or passenger?

❒ Driver ❒ Passenger

If passenger, where were you seated?

❒ Passenger's seat
❒ Rear seat, driver's side
❒ Rear seat, passenger's side

Were you wearing a seat belt at the time? ❒ Yes ❒ No

Was your vehicle moving or stopped? ❒ Moving ❒ Stopped

Did your vehicle strike another vehicle? ❒ Yes ❒ No

Did another vehicle strike yours? ❒ Yes ❒ No

Where was your vehicle hit?

❒ In the front
❒ In the rear
❒ On the driver's side
❒ On the passenger's side

Describe the collision: ______________________________

____

____

If your vehicle had airbags, did they deploy? ❒ Yes ❒ No

What were the road conditions?

❒ Dry
❒ Wet
❒ Icy
❒ Snow-packed
❒ Other, *describe* ____________________

How far did your car move after impact?

Car lengths ____________________

Feet ____________________

Questions about your circumstances at impact

Were you aware of the impending impact? ❒ Yes ❒ No

If yes, did you brace yourself before the impact? ❒ Yes ❒ No

Were you looking in a mirror? ❒ Yes ❒ No

If yes, please describe: ______________________________

What was your body position at time of impact?

❒ Neutral
❒ Forward
❒ Rotated: Left/Right

Did you strike another object?

❒ Steering wheel
❒ Dash
❒ Window
❒ Other ____________________

Did you experience any of the following at the time of impact?

❒ Cuts ❒ Abrasions, *where?* ____________________
❒ Bruises ❒ Dislocations
❒ Bumps ❒ Immediate dizziness
❒ Nausea ❒ Altered consciousness
❒ Immediate head pain
❒ Vision problems
❒ Immediate pain, *where?* ____________________
❒ Loss of consciousness, *how long?* ____________________

Questions about your circumstances after the accident

Were you able to get out of the vehicle and walk on your own? ❒ Yes ❒ No

Was your car drivable from scene of accident? ❒ Yes ❒ No

Where did you go after the accident?

❒ Home
❒ Work
❒ Hospital

Were you taken by ambulance? ❒ Yes ❒ No

Where? ______________________________

Who was at fault for this accident? ____________________

Did the police write any tickets? ❒ Yes ❒ No

To whom? ______________________________

If you went to a hospital, did you stay overnight? ❒ Yes ❒ No

If you went to a hospital, were any x-rays taken? ❒ Yes ❒ No

If x-rays were taken, what areas of your body were x-rayed?

____

How did you feel that night?

❒ Restless ❒ Stiff ❒ Fine
❒ In pain ❒ Sore

How did you feel the next day?

❒ Better ❒ Same ❒ Worse

Have you missed any time from work? ❒ Yes ❒ No

How Much? ______________________________

PATIENT TREATMENT HISTORY

LIST **ALL** DOCTORS, TESTS, AND TREATMENT YOU HAVE RECEIVED SINCE YOUR INJURY
Start with the first doctor/healthcare provider/hospital you saw after your injury and check all tests/treatments that apply

1. Name of hospital/doctor/therapist/medical center:
   Date of visit:
   Indicate what was done by checking the appropriate boxes:
   - ❐ Exam Consultation
   - ❐ X-ray of neck
   - ❐ X-ray of lower back
   - ❐ Other x-rays
   - ❐ MRI/CT scan
   - ❐ Other diagnostic test
   - ❐ Rehabilitation
   - ❐ Physical Therapy
   - ❐ Exercise recommended
   - ❐ Medication prescribed
   - ❐ Neck collar
   - ❐ Low back brace
   - ❐ Spinal manipulation/adjustments
   - ❐ Muscle massage/myotherapy
   - ❐ Heat packs
   - ❐ Cold/ice packs
   - ❐ Ultrasound/Electrical muscle stimulation
   - ❐ Other, *describe below:*

   ____

   Indicate if treatment:
   - ❐ Made condition worse
   - ❐ Did not help
   - ❐ Helped

2. Name of hospital/doctor/therapist/medical center:
   Date of visit:
   Indicate what was done by checking the appropriate boxes:
   - ❐ Exam Consultation
   - ❐ X-ray of neck
   - ❐ X-ray of lower back
   - ❐ Other x-rays
   - ❐ MRI/CT scan
   - ❐ Other diagnostic test
   - ❐ Rehabilitation
   - ❐ Physical Therapy
   - ❐ Exercise recommended
   - ❐ Medication prescribed
   - ❐ Neck collar
   - ❐ Low back brace
   - ❐ Spinal manipulation/adjustments
   - ❐ Muscle massage/myotherapy
   - ❐ Heat packs
   - ❐ Cold/ice packs
   - ❐ Ultrasound/Electrical muscle stimulation
   - ❐ Other, *describe below:*

   ____

   Indicate if treatment:
   - ❐ Made condition worse
   - ❐ Did not help
   - ❐ Helped

3. Name of hospital/doctor/therapist/medical center:
   Date of visit:
   Indicate what was done by checking the appropriate boxes:
   - ❐ Exam Consultation
   - ❐ X-ray of neck
   - ❐ X-ray of lower back
   - ❐ Other x-rays
   - ❐ MRI/CT scan
   - ❐ Other diagnostic test
   - ❐ Rehabilitation
   - ❐ Physical Therapy
   - ❐ Exercise recommended
   - ❐ Medication prescribed
   - ❐ Neck collar
   - ❐ Low back brace
   - ❐ Spinal manipulation/adjustments
   - ❐ Muscle massage/myotherapy
   - ❐ Heat packs
   - ❐ Cold/ice packs
   - ❐ Ultrasound/Electrical muscle stimulation
   - ❐ Other, *describe below:*

   ____

   Indicate if treatment:
   - ❐ Made condition worse
   - ❐ Did not help
   - ❐ Helped

4. Name of hospital/doctor/therapist/medical center:
   Date of visit:
   Indicate what was done by checking the appropriate boxes:
   - ❐ Exam Consultation
   - ❐ X-ray of neck
   - ❐ X-ray of lower back
   - ❐ Other x-rays
   - ❐ MRI/CT scan
   - ❐ Other diagnostic test
   - ❐ Rehabilitation
   - ❐ Physical Therapy
   - ❐ Exercise recommended
   - ❐ Medication prescribed
   - ❐ Neck collar
   - ❐ Low back brace
   - ❐ Spinal manipulation/adjustments
   - ❐ Muscle massage/myotherapy
   - ❐ Heat packs
   - ❐ Cold/ice packs
   - ❐ Ultrasound/Electrical muscle stimulation
   - ❐ Other, *describe below:*

   ____

   Indicate if treatment:
   - ❐ Made condition worse
   - ❐ Did not help
   - ❐ Helped