

CONFIDENTIAL PATIENT INFORMATION

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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 Work Status: Working without restrictions Not working/off work since _____
 Part-time Working with restrictions Retired

Employer: _____ Occupation: _____

Job Description: _____ Years Employed: _____

Address: _____
Street Address/P.O. Box City State Zip

Date of injury, surgery, or onset of symptoms: _____ **Emergency Contact, not living with you:**

What type of injury are we seeing you for? Name: _____
 Auto Sports Injury No specific trauma Phone #: _____ Relationship: _____
 Work Slip & Fall Other

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.

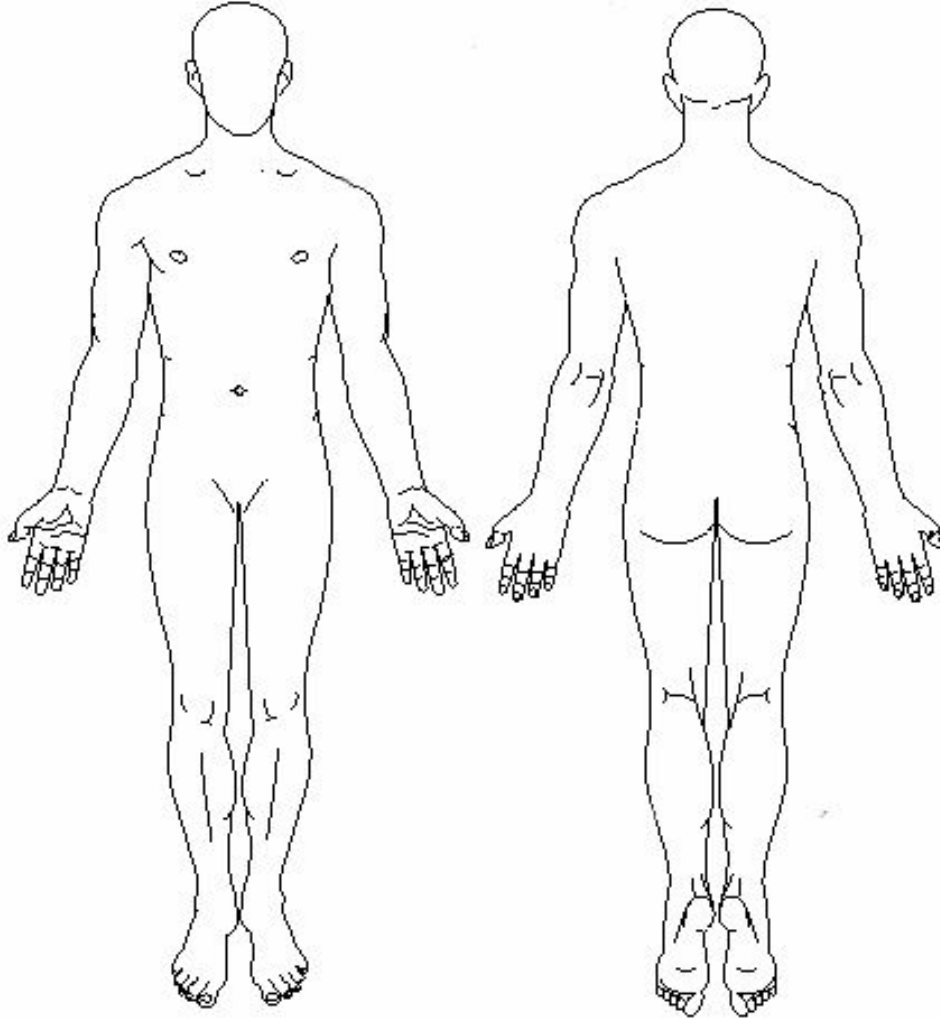
 Signature of Patient (Guardian, if Minor) Date Signature of Witness Date

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:

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

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

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

	No	Yes		No	Yes		No	Yes
Constitutional			Respiratory			Eye		
Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Chest Pain	<input type="radio"/>	<input type="radio"/>	Eye Pain	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>	Failing Vision	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>	Difficulty Breathing	<input type="radio"/>	<input type="radio"/>	Far Sighted	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Spitting Up Blood	<input type="radio"/>	<input type="radio"/>	Near Sighted	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	Spitting Up Phlegm	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	Wheezing	<input type="radio"/>	<input type="radio"/>	Blurred Vision	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>			
Weight Loss	<input type="radio"/>	<input type="radio"/>				Ears, Nose & Throat	No	Yes
Loss of Sleep	<input type="radio"/>	<input type="radio"/>	Gastrointestinal	No	Yes	Ringing in Ears	<input type="radio"/>	<input type="radio"/>
Night Sweats	<input type="radio"/>	<input type="radio"/>	Excessive Belching	<input type="radio"/>	<input type="radio"/>	Colds	<input type="radio"/>	<input type="radio"/>
			Excessive Gas	<input type="radio"/>	<input type="radio"/>	Deafness	<input type="radio"/>	<input type="radio"/>
Psychiatric	No	Yes	Colitis	<input type="radio"/>	<input type="radio"/>	Earaches	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	Colon Trouble	<input type="radio"/>	<input type="radio"/>	Ear Discharge	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	Ear Noise	<input type="radio"/>	<input type="radio"/>
Mood Swings	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	Enlarged Glands	<input type="radio"/>	<input type="radio"/>
			Difficult Digestion	<input type="radio"/>	<input type="radio"/>	Enlarged Thyroid	<input type="radio"/>	<input type="radio"/>
Musculoskeletal	No	Yes	Bloated Abdomen	<input type="radio"/>	<input type="radio"/>	Gum Trouble	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Excessive Hunger	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>
Bursitis	<input type="radio"/>	<input type="radio"/>	Gallbladder Trouble	<input type="radio"/>	<input type="radio"/>	Hoarseness	<input type="radio"/>	<input type="radio"/>
Foot Trouble	<input type="radio"/>	<input type="radio"/>	Hemorrhoids	<input type="radio"/>	<input type="radio"/>	Nasal Obstruction	<input type="radio"/>	<input type="radio"/>
Hernia	<input type="radio"/>	<input type="radio"/>	Intestinal Worms	<input type="radio"/>	<input type="radio"/>	Nose Bleeds	<input type="radio"/>	<input type="radio"/>
Neck Pain	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>	Sinus Infections	<input type="radio"/>	<input type="radio"/>
Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Liver Trouble	<input type="radio"/>	<input type="radio"/>	Sore Throat	<input type="radio"/>	<input type="radio"/>
Low Back Pain	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>			
Fractures	<input type="radio"/>	<input type="radio"/>	Stomach Pain	<input type="radio"/>	<input type="radio"/>	Genitourinary	No	Yes
			Poor Appetite	<input type="radio"/>	<input type="radio"/>	Blood in Urine	<input type="radio"/>	<input type="radio"/>
Cardiovascular	No	Yes	Vomiting	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>
Hardening of Arteries	<input type="radio"/>	<input type="radio"/>	Vomiting of Blood	<input type="radio"/>	<input type="radio"/>	Kidney Infection	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>				Painful Urination	<input type="radio"/>	<input type="radio"/>
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	Skin	No	Yes	Prostate Trouble	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Poor Circulation	<input type="radio"/>	<input type="radio"/>	Dryness	<input type="radio"/>	<input type="radio"/>	Are You Pregnant?	<input type="radio"/>	<input type="radio"/>
Rapid Heartbeat	<input type="radio"/>	<input type="radio"/>	Hives / Allergy	<input type="radio"/>	<input type="radio"/>			
Slow Heartbeat	<input type="radio"/>	<input type="radio"/>	Itching	<input type="radio"/>	<input type="radio"/>	Neurological	No	Yes
Swelling of Ankles	<input type="radio"/>	<input type="radio"/>	Varicose Veins	<input type="radio"/>	<input type="radio"/>	Tremors	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>	Skin Eruptions (Rash)	<input type="radio"/>	<input type="radio"/>	Fainting Spells	<input type="radio"/>	<input type="radio"/>
						Coordination Difficulty	<input type="radio"/>	<input type="radio"/>

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	<i>If yes, please describe:</i>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: <input type="checkbox"/> 1/2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 or more How long? _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ or # Drinks per week _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> 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:
