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PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

Primary Email _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

Approximately, when did your injury or condition occur? ___/___/____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

Describe your purpose of this appointment:

☐No particular condition or symptoms—just seeking general good health

How did your symptoms begin? _____

Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain.)

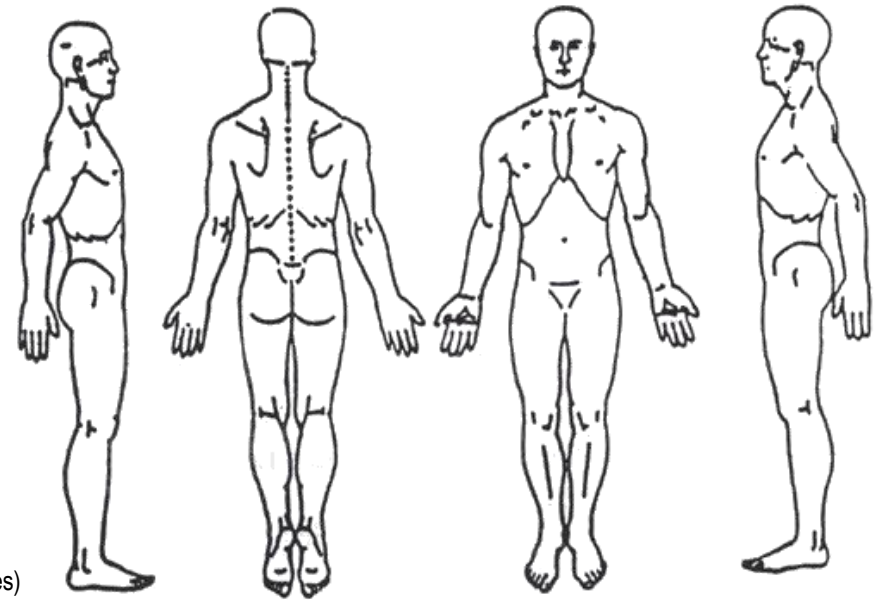
Condition/Problem	Severity	Frequency (%of week)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptoms (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

Symptoms (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

Symptoms (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

(Please mark the figures where you experience pain.)



Symptoms are worse in the (circle what applies)

Moring – Afternoon – Night – Increase during the day – Same all Day – Decrease during the Day

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who the patient has seen for the condition or symptoms:

Name	Date of Last Visit	Treatment Type	Result of Treatment
_____	_____	_____	_____
_____	_____	_____	_____

Circle the things that make your problem worse:

Bending – Lying – Walking – Standing – Sitting – movement – Twisting – Lifting - Sleeping

Is this condition interfering with _____ Work _____ Sleep _____ Daily Routine ____ Recreation?

Is there anything you can do to relieve the problems? ____ No ____ Yes Describe _____

If No, what have you tried that has not helped? _____

Any other musculoskeletal problems? _____ No _____ Yes .....Neurological problems? _____ No _____ Yes

Medical History:

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

Date of last physical examination: ____/____/____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Surgeries/Hospitalizations: _____

_____

Do you have any allergies (please list all): _____

_____

Are you currently taking any medications or drugs (please list all): _____

_____

Do you smoke? ☐ YES ☐ NO

If YES how frequently: _____ Approximate date started: ____/____/____

Do you drink alcohol? ☐ YES ☐ NO

If YES how frequently: _____

Optional Questions

Race

____ Decline to Specify
____ American Indian or Alaskan Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White
____ Other Race

Preferred Language _____ ____ Decline to Specify

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____