

PATIENT INFORMATION SHEET

Name: _____

Sex: M / F

Date: _____

Full Address: _____

Home Phone #: _____

Cell Phone #: _____

Date of Birth: _____

Email #: _____

May we send you E-mails YES NO

Do you have a family history of: Heart Disease Arthritis Cancer Diabetes

Other: _____

Current Medication: Steroids Pain Relievers Beta Blockers Blood Thinners Gabapentin Neurotin

Lyrica Statin Drugs Other Medication _____

Present Complaint: _____

How long have you been experiencing your main complaint? _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Do you have PAIN or DIFFICULTY performing any of the following activities: Work ____ Sleep ____ Daily Routine /
 Personal Care ____ Walking ____ Sitting ____ Recreation ____ Lifting ____ Other _____

Is condition getting progressively worse? _____

Have you seen any other Doctors for this condition? _____

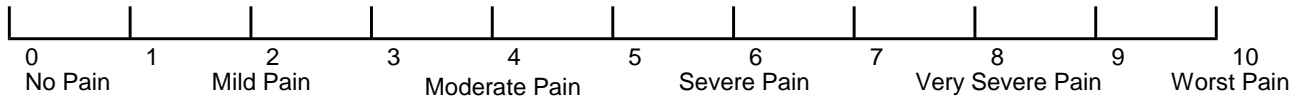
What other treatments have you tried? Please list them and their effectiveness: _____

If you experience/ or have experienced any of the following symptoms, please check the box to the left;

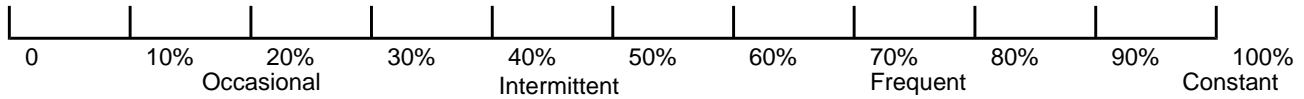
| | | | | | |
|--------------------------|-------------------|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | Headaches | <input type="checkbox"/> | Pins and Needles in legs | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | Pins and Needles in Arms | <input type="checkbox"/> | Loss of Smell |
| <input type="checkbox"/> | Sleeping Problems | <input type="checkbox"/> | Numbness in Fingers | <input type="checkbox"/> | Loss of Taste |
| <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | Numbness in Toes | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | Feet Cold |
| <input type="checkbox"/> | Tension | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | Hands Cold |
| <input type="checkbox"/> | Irritability | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Stomach Upset |
| <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | Lights Bothers Eyes | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | Loss of Memory | <input type="checkbox"/> | Cold Sweats |
| <input type="checkbox"/> | Face Flushed | <input type="checkbox"/> | Ears Ring | <input type="checkbox"/> | Loss of Balance |
| <input type="checkbox"/> | Neck Stiff | <input type="checkbox"/> | Fever | <input type="checkbox"/> | Buzzing in Ears |

PATIENT NAME: _____

1. On the scale below, please **circle** the **SEVERITY** of your **main complaint** (at its worst):

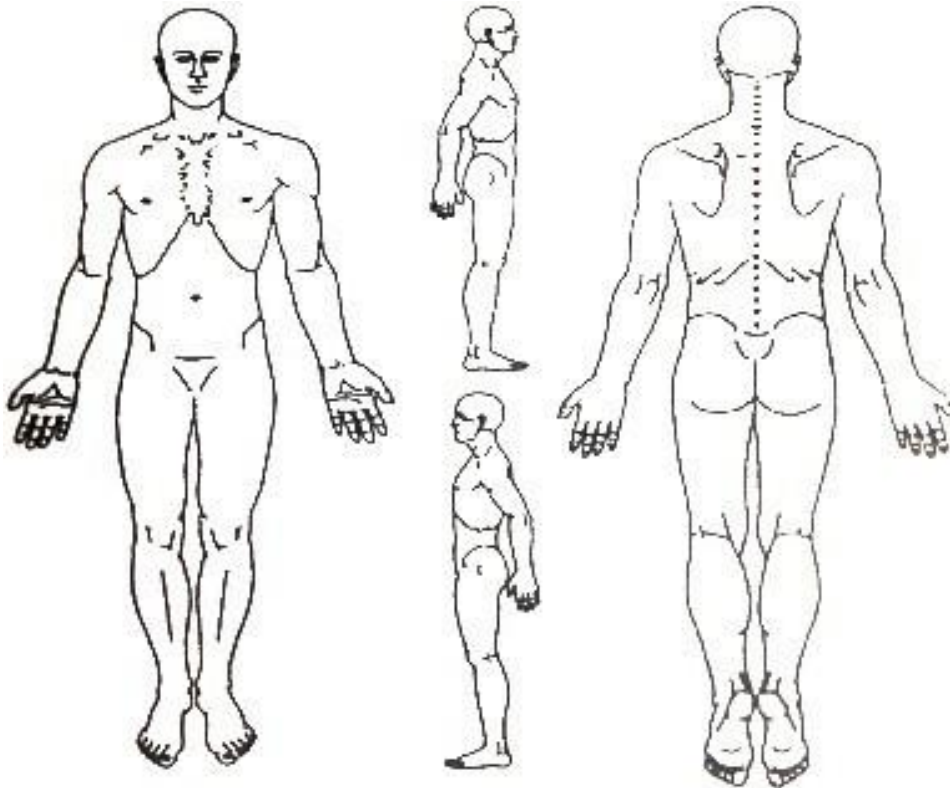


2. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:



3. On the diagram below, please indicate **where** you are experiencing **all** your present complaints by using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **TR:** throbbing pain **N:** numbness **T:** tingling



Primary Insurance Information

Who is responsible for your bill? You and.... (Please, circle appropriate indicator)

Myself Only Spouse Worker's Comp Auto Insurance Medicare

Health Insurance Carrier: _____ (PPO, HMO, EPO)

ID # _____ Group # _____

Holder's name: _____

Provider Service Phone # : _____

Secondary/Supplemental Insurance Information

Who is responsible for your bill? You and.... (Please, circle appropriate indicator)

Myself Only Spouse Worker's Comp Auto Insurance Medicare

Health Insurance Carrier: _____ (PPO, HMO, EPO)

ID # _____ Group # _____

Holder's name: _____

Provider Service Phone #: _____

Workers Compensation Injury/ Auto/ Personal Injury

Have you filed and injury report with your employer? Yes/ No Date __/__/____

Claim # _____

Carrier: _____ Policy # _____

Carrier's Phone # (____)____-____ Adjuster: _____

Patient Billing/ Payment Understanding /Authorization of Care

I understand and agree that health /accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am directly responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. It is understood and agreed the amount paid the Doctor, for x-rays, is for the examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while the patient is in this office. As the patient, I also agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I give authority for these procedures to be performed.

Patient Print Name: _____ Date: ____/____/____

Patient signature authorizing care: _____

Guardian or Spouse's signature authorizing care: _____

Relationship to patient: _____

Clinic's Notice and Privacy and Practices

I acknowledge that I have received the Clinic's Notice and Privacy and Practices for protected health information:

Patient Signature: _____ Date: ____/____/____