Patient Information Form

Barcode/Z #:

Name: _____ **Today's Date:** _____

Please complete the Patient Information Form and the Patient Intake Questionnaire. Thank You.

Patient Information:

Full Name: _____ Date of Birth: ____/____/____
Address: _____ Social Sec #: ____-____-____
City: _____ Home Phone: _____
State: _____ Zip: _____ Cel Phone: _____
Email Address: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Phone #: _____

Spouse / Parent / Guardian Information:

Full Name: _____ Date of Birth: ____/____/____
Address: _____ Social Sec #: ____-____-____
City: _____ Home Phone: _____
State: _____ Zip: _____ Cel Phone: _____
Email Address: _____
Employer: _____ Work Phone: _____

Insurance and Primary Care Physician (PCP) Information:

Company: _____ Member/Acct#: _____
Employer: _____ Group #: _____
Member / Policyholder's Name: _____

PCP Name: _____ Phone #: _____
City: _____ State: _____

Please sign this form, and move on to the Patient Intake Questionnaire.

_____
(Your Signature) (Date)

Patient Intake Questionnaire

Barcode/Z #:

Name: _____ **Today's Date:** _____

Reason For Visit:

- ❑ Pain Symptoms
- ❑ Wellness Visit
- ❑ Auto Accident
- ❑ Work Related Injury
- ❑ Sports Injury
- ❑ Other Injury

Date of Injury: _____

❑ **Auto Accident:**

❑ Driver ❑ Passenger, Front ❑ Passenger, Rear ❑ Pedestrian

Were You Wearing Seat Belt? ❑Yes ❑No
Is there a Police Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Did You Receive Aid at Scene? ❑Yes ❑No
Were You Taken to Hospital? ❑Yes ❑No

Type of Car? _____ Year? _____ Was the Car Driveable? ❑Yes ❑No

Did You Hit? ❑ Air Bag ❑ Steering Wheel ❑ Side Door ❑ Dashboard ❑ Windshield

Describe the Accident: _____

_____

_____

❑ **Work Related Injury:**

Job Title: _____ Company: _____ How long? _____

Describe Your Normal Work Activities: _____

Did You File a Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Were You Taken to Hospital? ❑Yes ❑No

Explain in Detail What Caused the Injury: _____

_____

_____

❑ **Sports or Other Injury:**

Explain in Detail What Caused the Injury: _____

_____

_____

Where Did the Injury Occur? _____

Did You File a Report? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Were You Taken to Hospital? ❑Yes ❑No

Primary Symptoms: (Check all that apply)

☐ Headache	☐ Migraines	☐ Neck Pain	☐ Neck Stiffness	☐ Shoulder Pain
☐ Arm Pain	☐ Low Back Pain	☐ Hip Pain	☐ Leg Pain	☐ Back Pain
☐ Soreness	☐ Discomfort	☐ Numbness	☐ Tingling	☐ Dizziness
☐ Fatigue	☐ Weakness	☐ Memory Loss	☐ Hearing Loss	☐ Depressed
☐ Elbow Pain	☐ Knee Pain	☐ Fever	☐ Sweating	☐ Sleep Problems

Other: _____

Additional Symptoms: _____

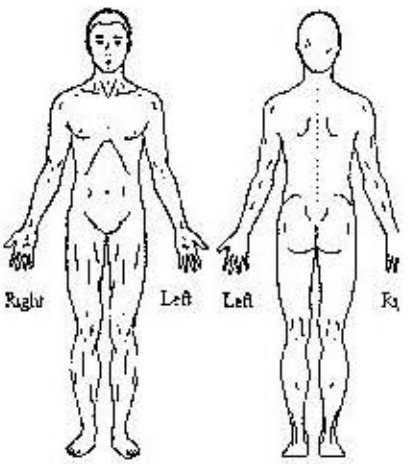
_____

Where Specifically Does it Hurt? (Check all that apply)

☐ Neck	☐ Upper Back	☐ Mid Back	☐ Lower Back	☐ Left Hip	☐ Right Hip
☐ Left Shoulder	☐ Right Shoulder	☐ Left Arm	☐ Right Arm	☐ Left Elbow	☐ Right Elbow
☐ Left Leg	☐ Right Leg	☐ Left Knee	☐ Right Knee	☐ Left Ankle	☐ Right Ankle
☐ Head	☐ Eyes	☐ Ears	☐ Chest	☐ Abdomen	☐ Buttocks

☐ Other: _____

Please Describe the Pain and Place an "X" on the Picture:



Severity:
☐ Mild ☐ Mild-to-Mod ☐ Moderate ☐ Mod-to-Severe ☐ Severe

Frequency:
☐ Once ☐ Intermittent ☐ Occasional ☐ Frequent ☐ Constant

Quality:
☐ Dull ☐ Medium ☐ Sharp ☐ Stabbing ☐ Burning

The Pain is worse: (Check all that apply)
☐ Morning ☐ Midday ☐ After Work ☐ Evening ☐ Nighttime

Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:

Circle One: 1 2 3 4 5 6 7 8 9 10

Have you Been Treated for this Current Condition in the Past?

☐ Yes ☐ No When? _____ By Whom? _____

What Activities of Daily Living are you unable to perform due to your pain?

☐ Sleeping	☐ Walking	☐ Standing	☐ Sitting	☐ Running	☐ Climbing
☐ Bathing	☐ Showering	☐ Dressing	☐ Shoes	☐ Toileting	☐ Cleaning
☐ Self Care	☐ Family Care	☐ Child Care	☐ Home Care	☐ Driving	☐ Gardening
☐ Working	☐ Lifting	☐ Desk Work	☐ Traveling	☐ School	☐ Concentrate

Describe how the pain affects these Activities of Daily Living:

_____

Check the box that describes the pain and Activities of Daily Living (ADL):

1 – No Pain	2 – Slight Discomfort	3 – Pain with No Effect on ADL's	4 – Pain with a Little Effect on ADL's	5 – Pain Prevents Any ADL's	6 – Pain Limits Work and Prevents Any ADL's	7 – Pain Prevents Both Work and ADL's	8 – Pain Prevents Working, ADL's and Activity	9 – Pain Keeps Me in Bed or Sitting at All Times	10 – Pain is Horrible. Cannot Tolerate Movement

ADDITIONAL COMPLAINTS: _____

_____

PAST HISTORY:

What other conditions have you been treated for? (Explain in detail)

_____

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

Medical History – (Check all that apply)

You:

☐ Diabetes	☐ Arthritis	☐ AIDS	☐ Sciatica	☐ Bursitis	☐ Osteoporosis
☐ Alzheimer	☐ Kidney Dis.	☐ Gout	☐ Amputation	☐ Ulcers	☐ High Blood Pressure
☐ Cancer	☐ Heart Attack	☐ Stroke	☐ COPD	☐ Scoliosis	☐ Low Blood Pressure
☐ Ulcers	☐ Deafness	☐ Blindness	☐ Migraines	☐ Disc Disorder	☐ Neuralgia
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	☐ Varicose Vein	☐ Convulsions
☐ Fainting	☐ Sweats	☐ Chills	☐ Nervousness	☐ Eczema	☐ Prostrate Trouble
☐ Bleeding	☐ Tonsilitis	☐ Earache	☐ Hemorrhoids	☐ Pregnancy	☐ Neuro-Muscular Disease

☐ Other: (Be specific) _____

Your Family:

_____

List any Current Allergies: (Be specific)

_____

Current Medications You are Taking: (Be specific)

_____

_____

Social Activities:

☐ Smoke Cigarettes ____ # packs per day ☐ Smoke Cigars ☐ I don't smoke
☐ Drink Alcohol Beverages ___ # per day, or ___ # per week ☐ I don't drink alcohol.
☐ Beer ☐ Wine ☐ Mixed Drinks
☐ I admit to history of Recreational Drug Use. ☐ I deny history of Recreational Drug Use.
☐ I am currently Pregnant. Due Date: _____

Comments: _____

Please sign this form and thank you for visiting our office!

_____ _____

(Your Signature) (Date) (Provider Signature) (Date)