Patient Information

Last Name: _____First Name:_____

Sex: ___Date of Birth: _____ SS#: _____-_____-_____

Address: _____ City: _____State: ___

Zip Code: _____ Work#: ( ) ____-_____ Home#: ( ) ____-_____

Mobile#: ( ) ___-_____ Email: _____

*Marital Status: **Circle One**: Single Married Divorced Widowed Domestic Partner*

Employer's Name: _____

Employer's Address_____

Employer's Phone # ( ) ____-_____

***Referring Physician's Name:** _____ **Diagnosis:** _____*

Injury: Work or Auto related? _____ Date Accident Occurred_____

Emergency Contact: _____ Phone#: ( ) _____-_____

Insurance Information:
Primary Insurance Co. Name: _____Policy#:_____
Subscriber Name: _____ SS#:____-___-____ Date of Birth:_____
Subscriber Employer's Name:_____

Secondary Insurance Co. Name: _____ Policy #:_____
Subscriber Name:_____ SS#:____-___-_____ Date of Birth:_____

Workers Comp Insurance Co. Name: _____ Claim #: _____
Adjustor's Name:_____ Adjustor's #:_____
State Accident Occurred:_____

3rd Party Insurance: Attorney Name:_____ Phone #:( ) ____-_____

Patient Questionnaire/ History

Name: _____ Date of Birth: _____

What is your Chief Complaint?

_____
_____

Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____
Loss of function_____

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

When and how did this problem begin?

_____
_____

What makes your symptoms/ pain worse?

_____
_____

What makes your symptoms/ pain lessen?

_____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain:

Worst it has been: /10, Average pain level: /10, Current pain level: /10.

Are your symptoms worse in the: __Morning ___Afternoon __Evening

Are your symptoms: ___Improving ____Worse __Stable

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Please answer the following questions: **By circling Yes or No and give details as needed.**

1) Do have a history of Seizures? If so, please explain. **Yes or No**

_____

2) Do you have a Cardiac Pacemaker? **Yes or No**
3) Are you Pregnant? **Yes or No**
4) Have you ever been diagnosed with Cancer? **Yes or No**
If so, what type and when diagnosed?

_____

5) Have you had a history of headaches or migraines? **Yes or No**
6) Do you experience any dizziness or vertigo? **Yes or No**
7) Do you have unexplained night time pain? **Yes or No**
8) Do you have unexplained weight loss or gains? **Yes or No**
9) Any recent fevers, chills, or night sweats? **Yes or No**
10) Any increase in generalized fatigue or weakness? **Yes or No**
11) Any recent changes in bowel or bladder habits? **Yes or No**
12) Any recent chest pains or chest pain with exercise? **Yes or No**
13) Do the current problems interrupt your sleep? **Yes or No**
14) Do you have any intolerance to hot or cold? **Yes or No**
15) Do you have any abnormal bruising or bleeding disorders? **Yes or No**
16) Have you had any skin changes, such as rashes or discoloration? **Yes or No**
17) Do you have any Metal Implants? **Yes or No**
18) Have you had a recent episode of nausea/vomiting? **Yes or No**
19) Do you have osteoporosis? **Yes or No**
Date of your last bone scan: _____
20) Do you have any Medical allergies? **Yes or No**
21) Are you allergic to LATEX? **Yes or No**
22) Have you noticed any shortness of breath or in exercise tolerance? **Yes or No**
23) Do you use any assistive device? (Cane, RW, foot orthotics) **Yes or No**
24) Do you have high blood pressure? **Yes or No**
25) Do you have any cardiac problems? **Yes or No**
26) Do you have diabetes? **Yes or No**
27) Do you have a history of neck or back problems? **Yes or No**
28) Do you have a hernia? **Yes or No**
29) Have you had any recent falls in the last 6 months? **Yes or No**
If so, how many?_____

Any other illness, past injuries I should be aware of?

_____
_____
_____
_____
_____

Past surgeries*: ___YES ___NO*
Procedure and date performed:

_____
_____
_____

*List the medications you are currently taking (over the counter/prescription):*_____
_____
_____
_____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

Hand dominance: Circle one: ***Right or Left***

***Patient's signature: __*_____ *Date signed:* _____