# Confidential Medical History/Evaluation

Today's Date: _____ Referring MD/Company: _____ Patient Acct#_____
Name: _____ Date of Birth: _____ /_____ /_____ SS# _____
Address: _____City: _____ State _____ Zip_____ E Mail: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ Occupation: _____
HOW DID YOU HEAR ABOUT US? : _____
Insurance Company: _____ Name of Insured: _____ Relation: _____
Subscriber ID: _____ Group #: _____ Insured's Employer: _____
**Chief Complaint**: _____
**Is this injury? (Please circle): Work Related Auto Accident Other** _____ Date of Injury: _____ Pain Onset: _____
**Current Symptoms (Please circle): Pain Numbness Stiffness Weakness Condition (Please circle): New Acute Chronic**
List any/all medications you are currently taking: _____
Are you allergic to any medications? _____
List any surgeries: _____
Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI X-Rays Other: _____

| **Do you have any of the following?** | **YES** | **NO** | **Pain when performing the following activities?** | **MILD** | **MODERATE** | **SEVERE** | **UNABLE** |
|---|---|---|---|---|---|---|---|
| Asthma, Bronchitis or Emphysema | | | Bending | | | | |
| Shortness of Breath/Chest Pain | | | Care for Infirm Family | | | | |
| Coronary Heart Disease | | | Carrying Groceries | | | | |
| Do you have a Pacemaker | | | Sit to Stand | | | | |
| High Blood Pressure | | | Climb Stairs | | | | |
| Heart Attack/Surgery | | | Driving | | | | |
| Stroke/TIA | | | Extended Computer Use | | | | |
| Blood Clot/Emboli | | | Feeding (Self) | | | | |
| Epilepsy/Seizures | | | Household Chores | | | | |
| Thyroid Trouble/Goiter | | | Kneeling | | | | |
| Anemia | | | Lift Children | | | | |
| Diabetes | | | Pet Care | | | | |
| Cancer or Chemo/Radiation | | | Reading (Concentration) | | | | |
| Arthritis/Swollen Joints | | | Self Care-Bathing | | | | |
| Osteoporosis | | | Self Care-Dressing | | | | |
| Varicose Veins | | | Self Care-Shaving | | | | |
| Gout | | | Sexual Activities | | | | |
| Sleeping Difficulties | | | Sleep | | | | |
| Emotional/Psychological Problems | | | Sitting (Prolonged) | | | | |
| Bowel or Bladder Problems | | | Standing (Prolonged) | | | | |
| Severe/Frequent Headaches | | | Walking | | | | |
| Vision/Hearing Difficulties | | | Yard Work | | | | |
| Dizziness or Faintness | | | Sports | | | | |
| Are you pregnant? | | | Recreational Activities | Daily: | Weekly: | | |
| Smoking | Daily: | Weekly: | Exercise | Daily: | Weekly: | | |
| Alcohol Consumption | Daily: | Weekly: | | | | | |
| Are you aware of your Diagnosis? | Yes: | No: | Are you aware of your Prognosis? | Yes: | No: | | |

I Ihereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to **FUNCTIONAL HEALTH + WELLNESS** regardless of participation "In" or "Out-of Network". Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.
**Patient/Parent/Guardian Signature:** _____ **Date** : _____ I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.
**Patient/Parent/Guardian Signature**: _____ **Date** : _____