



MRN# _____

Appointment Date: _____
Appointment Time: _____

****PLEASE USE BLACK INK****

Private Insurance

Patient Information

Please Print

Name _____ Date _____

Date of Birth _____ Social Security #: _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Occupation _____ **Unemployed**

Employer _____ Business Phone _____

Employer Address _____ Length of Employment _____

Second Employer _____ Phone: _____

Second Employer Address _____

Sex: Male Female Height _____ Weight _____ Dominant Hand: Left Right

Race: African American Asian Caucasian Hispanic Other

Are you: Married Single Domestic Partnership Divorced Separated Widowed

Spouse's Name: _____

Emergency Contact Name _____ Relationship _____

Contact Phone _____

Name of nearest relative not living with you: _____ Phone: _____

Patient's Signature: _____ Employee Initials: _____

Private Health Insurance Information

Health Insurance Carrier _____

Health Insurance Address _____

Policy Number _____ Group Number _____

Policy Holder _____ DOB of Policy Holder _____

Employer of Policy Holder _____ Relationship _____

Secondary Insurance Information

Health Insurance Carrier _____

Health Insurance Address _____

Policy Number _____ Group Number _____

Policy Holder _____ DOB of Policy Holder _____

Employer of Policy Holder _____ Relationship _____

Tertiary Insurance Information

Health Insurance Carrier _____

Health Insurance Address _____

Policy Number _____ Group Number _____

Policy Holder _____ DOB of Policy Holder _____

Employer of Policy Holder _____ Relationship _____

Patient's Signature: _____ Employee Initials: _____

Present Health

Why do you need an evaluation today? Check the appropriate area and briefly explain.
(Examples-pain, numbness, tingling, burning, weakness)

Neck Shoulder Elbow Wrist Low Back Hip Knee Leg Ankle Foot

Other (please specify): _____

When did the symptom(s) begin? _____

How did the pain symptom(s) start? Check the appropriate response or explain.

Suddenly Gradually Twisting Pulling Fall Lifting Bending Hit by Object
 Sports No Apparent Cause _____

Did you go to the hospital, E.R., or Urgent Care? Yes Date(s) _____ No

Name of hospital, E.R. or Urgent Care: _____

Did you have X-rays, MRI, CT Scan, or other diagnostic testing? _____

Have you been treated anywhere else for this accident? Yes No

If yes, where? _____ Phone Number: _____

Have you been injured prior to this accident? Yes No

Have you ever had a Disability Rating for a previous accident? Yes No

Please list any medications you are currently taking _____

Please list any supplements you are currently taking _____

Please list any allergies (including drug and **latex allergies**) you may have:

Who is your Primary Care Provider? _____ Phone: _____
Primary Care Provider Address _____

Patient's Signature: _____ Employee Initials: _____

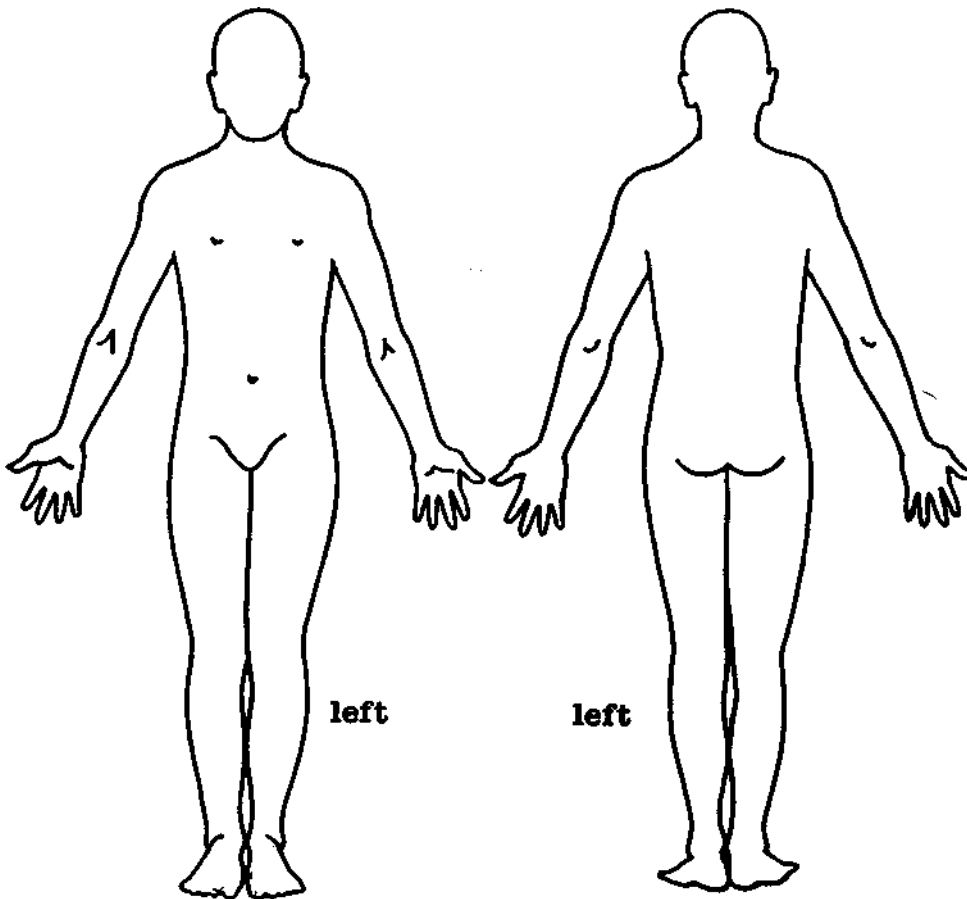
Pain Description

Please rate your pain on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt)

Areas of Injury	Pain Scale	Areas of Injury	Pain Scale	Areas of Injury	Pain Scale
Head		Left Shoulder		Right Shoulder	
Neck		Left Elbow		Right Elbow	
Upper Back		Left Wrist/Hand		Right Wrist/Hand	
Lower Back		Left Knee		Right Knee	
Hips		Left Ankle/Foot		Right Ankle/Foot	

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □	Pins & Needles: .-.	Aching pain: ±
Stabbing pain: ↑	Burning: #	Stiffness: u



Patient's Signature: _____ Employee Initials: _____

Review of Systems

Weight _____ Height _____

Medical History:

Please mark any of the symptoms that **apply to you TODAY**:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			Muscle Weakness		
Anxiety			Numbness or Tingling		
Chest Pain			Painful or Urgent Urination		
Cough			Rapid Hearth Beat		
Cuts that won't stop bleeding			Rash		
Depression			Shortness of Breath		
Fever/Chills			Swelling of Legs		
Frequent Urination			Vomiting		
Frequent/Easy Bruising			Discolored Stools		
Irregular Heart Beat			Wound Healing Problems		
Joint Pain or Swelling			Other: _____		
Muscle Pain or Swelling					

Check if you have had any of these conditions in the **PAST** or if there is any family history of these conditions:

MAJOR ILLNESS	YES	NO	FAMILY	MAJOR ILLNESS	YES	NO	FAMILY
Anemia				Liver Disease			
Arthritis				Kidney Disease			
Heart Arrhythmia/Palpitations				Loss of Vision			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer:				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder Disease				Reflux			
Gastric Ulcers				Skin Ulcer/Breakdown			
Glaucoma				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis-TB			
Hepatitis B				Urinary Infections			
Hepatitis C				Valve Disorders (Heart)			
High Blood Pressure				Wound Healing Problems			
HIV/AIDS				Orthopaedic Conditions:			
Immune Deficiency				Other: _____			

Patient's Signature: _____ Employee Initials: _____

Surgical History

Please list any surgeries and the dates they were performed:

Date:	Surgery:

Social History

Please Circle

Do you have Children?

Yes – How many: _____ No

Are you Pregnant? (**Women Only**)

Yes No

Do you Live Alone?

Yes No

Drugs/Alcohol:

History of Substance Abuse?

Yes No

Do you drink Alcoholic Beverages?

Yes – How much: _____ No

Do you smoke Cigarettes?

Yes - How much: _____ No

If you smoked in the past, how long has it been since you stopped?

0-3 months 3-6 months 6-12 months Over a year ago

Exercise:

Do you Exercise?

Daily Weekly Monthly Rarely Never

What type of Exercise?

Walking Running Swimming Weight Lifting Aerobics

Other _____

Patient's Signature: _____ Employee's Initials _____