

**PATIENT INFORMATION**

Date \_\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      Middle Initial

Address \_\_\_\_\_

\_\_\_\_\_  
City                                      State                                      Zip

Email Address \_\_\_\_\_

Cell(\_\_\_\_\_) \_\_\_\_\_ Home(\_\_\_\_\_) \_\_\_\_\_

Work(\_\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  M  F

Height \_\_\_\_\_ Weight \_\_\_\_\_  Married  Widowed  Single

Who is responsible for account? \_\_\_\_\_

In case of emergency please contact:

Name \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance Company** \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Member # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber's DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

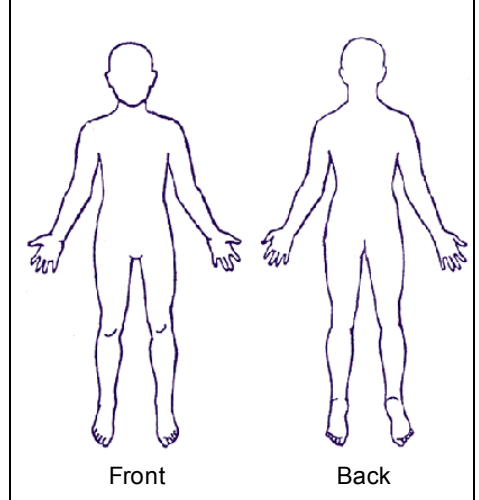
Member # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber's DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

**PATIENT CONDITION**

- (1) Primary health complaint? \_\_\_\_\_
- (2) When did your symptoms appear? \_\_\_\_\_
- (3) Are these symptoms progressively worse?  Yes  No
- (4) Mark an **X** on the picture where you are having symptoms.
- Type of Symptoms:  Sharp Pain     Dull Pain     Throbbing Pain  
 Burning     Numbness     Tingling     Aching  
 Cramping     Stiffness     Swelling
- (5) Rate the severity of your pain on a scale from 1 (least) to 10 (severe) \_\_\_\_\_
- (6) How often do you have this pain? \_\_\_\_\_
- (7) Is the pain constant or does it come and go? \_\_\_\_\_
- (9) Does the pain interfere with your:     Work     Sleep     Daily Routine     Recreation
- (10) Activities that are painful to perform:  Sitting     Standing     Walking     Lying Down     Bending



**ACCIDENT INFORMATION**

Are any of the above conditions due to an accident?  Yes  No    (If so) Date \_\_\_/\_\_\_/\_\_\_

Type of Accident:  Auto     Work     Home     Other

Signature \_\_\_\_\_ Date \_\_\_\_\_