Version 7/2/2015

Barcode Label

Interviewer: ___________
Office: ___________

Private Health Patient

PLEASE USE BLACK INK

Patient Information

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:________________

Private Health Insurance Information

Health Insurance Carrier ____ Waiver Signed ☐

Health Insurance Address____

Policy Number _____________________________________ Group Number______________________

Policy Holder ______________________________________ DOB of Policy Holder ________________

Employer of Policy Holder ____________________________________ Relationship _______________

Patient's Signature: _______________________________________

Provider's Initials:____________

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 condition? ☐ Yes ☐ No

If yes, where? ________________________________ Phone Number: ________________________________

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: ____ | Provider's Initials:____________

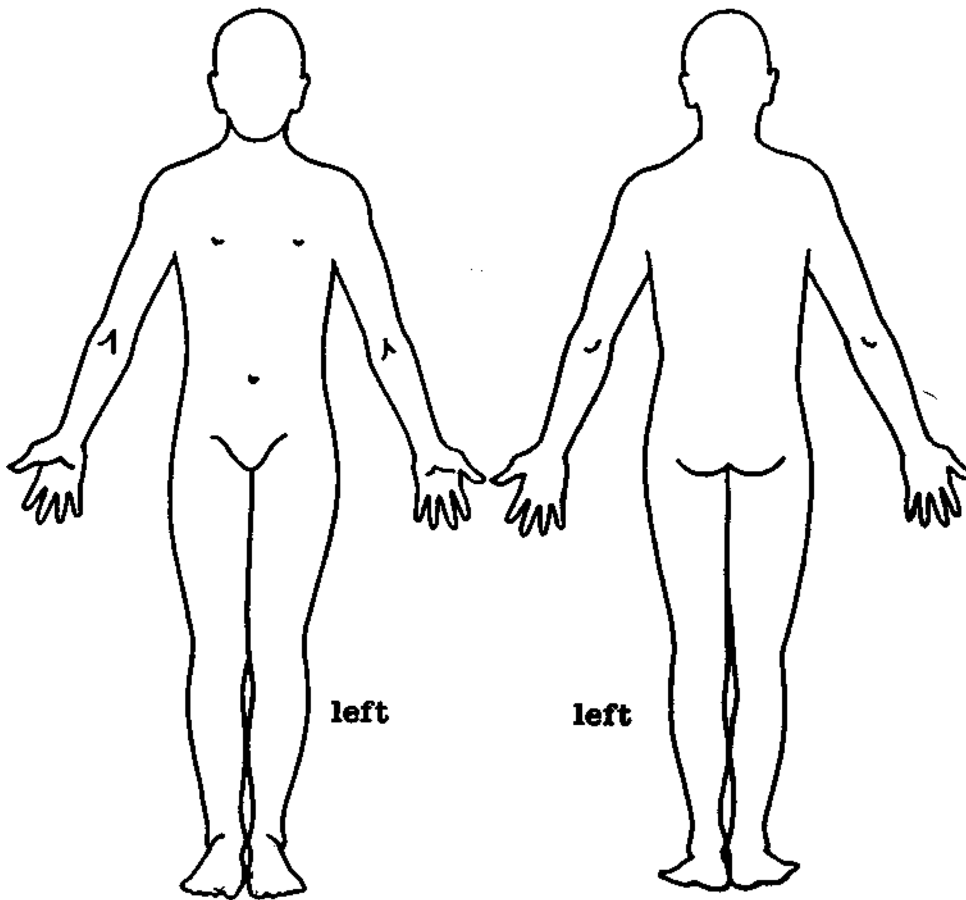
Pain Description

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: ____ Provider's Initials:____________

Review of Systems

Weight ____________ Weight 1 yr. Ago ___________ Max. Weight ______ When ________

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/Palpations				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: ____________________________________ Provider Initials:________

Surgical History

Please list any surgeries and the dates they were performed:

Date:	Surgery:

Social History

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: ____________________________ Provider Signature:___________________