

Barcode Label



Interviewer: _____
Office: _____

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

Patient Information

Please Print

Name _____ Date _____
 Date of Birth _____ Social Security #: _____
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ E-Mail Address _____
 Occupation _____
 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: _____ # of Children _____
 Emergency Contact Name _____ Relationship _____
 Contact Phone _____
 Health Insurance Carrier _____ Waiver Signed
 Health Insurance Address _____
 Policy Number _____ Group Number _____
 Policy Holder _____ DOB of Policy Holder _____
 Employer of Policy Holder _____ Relationship _____
 Name of nearest relative not living with you: _____ Phone: _____
 Have you ever been seen previously for the current condition? Yes No
 If yes, where? _____ Phone Number: _____

****Get copies of driver license, private insurance card and car insurance card – if applicable.****

Accident Information

If completing this section please also complete Duties Under Duress/Loss of Enjoyment Summary

How were you injured? Auto _____ W/C _____ Slip & Fall _____
 Auto Auto/While on Job Cab Bus Motorcycle Pedestrian

Date of Injury _____ What State? _____
 Brief description of how accident happened: _____

Did you strike your head or any other part of your body in this accident? _____

Attorney Name: _____ Atty Phone: _____

Patient's Initials: _____

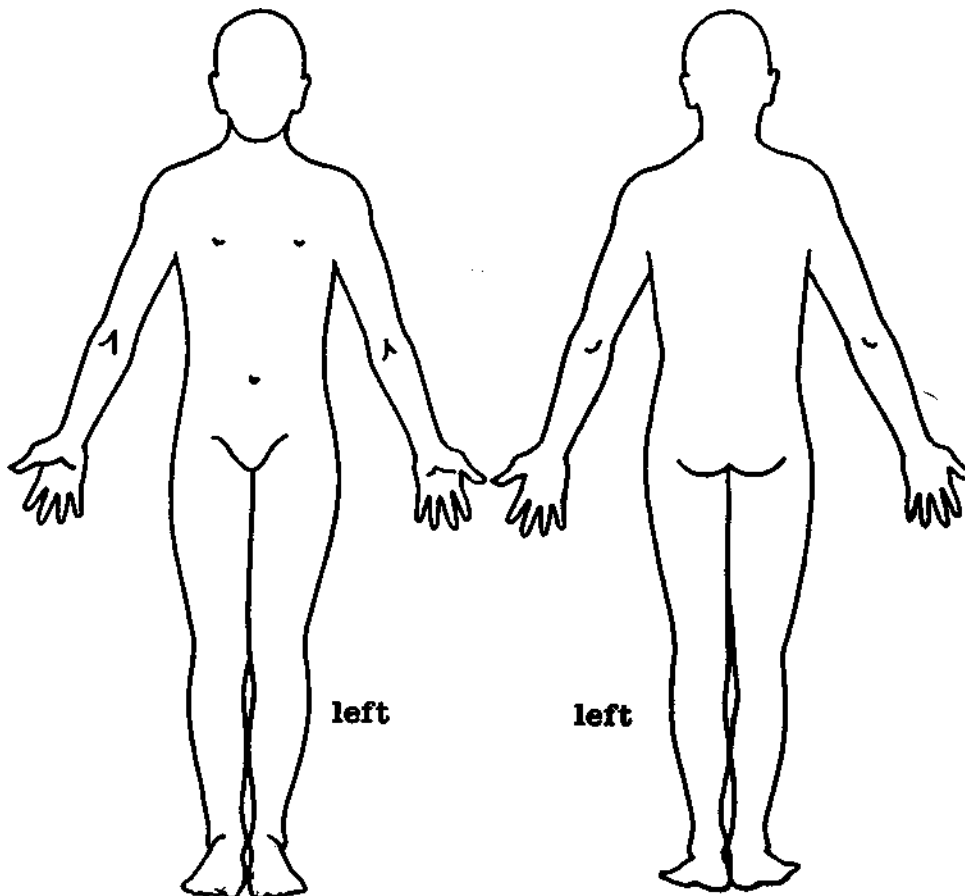
Pain Description

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: _____

Review of Symptoms-Past, Present and Family
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Weight _____ Weight 1 yr. ago _____ Max. Weight _____ When _____

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now P= a condition you have had in past N= never had F=Family

HEAD SYMPTOMS

Dizziness	Y P N F
Headaches	Y P N F
Head Injury	Y P N F
Blurred Vision	Y P N F
Seeing spots	Y P N F
Eye Tearing/ Eye Dryness	Y P N F
Double Vision	Y P N F
Cataracts	Y P N F
Eye Glasses or Contact Lenses	Y P N F
Impaired Hearing	Y P N F
Ear Ringing	Y P N F
Earaches	Y P N F

RESPIRATORY SYMPTOMS

Frequent Colds	Y P N F
Sinusitis	Y P N F
Postnasal Drip	Y P N F
Change in Taste	Y P N F
Cough	Y P N F
Sputum	Y P N F
Spit up Blood	Y P N F
Difficulty Breathing	Y P N F
Shortness of Breath	Y P N F
Asthma	Y P N F
Bronchitis	Y P N F
Pneumonia	Y P N F
Emphysema	Y P N F

DIGESTIVE SYMPTOMS

Nausea	Y P N F
Vomiting	Y P N F
Constipation	Y P N F
Blood in Stool	Y P N F
Gas/Bloating	Y P N F
Hemorrhoids	Y P N F
Belly Pain	Y P N F
Peptic Ulcer	Y P N F
Gall Bladder Disease	Y P N F

GENITOURINARY SYMPTOMS

Pain on Urination	Y P N F
Urinary Frequency	Y P N F
Kidney Stones	Y P N F
Blood in Urine	Y P N F
Hernia	Y P N F
Testicular pain/masses	Y P N F
Sexual Difficulties	Y P N F
Prostate Disease	Y P N F
Irregular Menses	Y P N F
Painful Menses	Y P N F
Spotting	Y P N F
Breast lumps/pain/discharge	Y P N F
Currently Pregnant	Y N

MUSCLE/JOINT SYMPTOMS

Joint Pain/Stiffness	Y P N F
Arthritis	Y P N F
Broken Bones	Y P N F
Muscle Spasms	Y P N F
Deep Leg Pain	Y P N F
Neck Pain	Y P N F
Back Pain	Y P N F
Lower Back Pain	Y P N F
Extremity Pain	Y P N F
Chest Pain	Y P N F
Right/Left Arm Pain/Tingling	Y P N F
Right/Left Leg Pain/Tingling	Y P N F
Right/Left Foot Pain/Tingling	Y P N F
Right/Left Hand Pain/Tingling	Y P N F
Fingers/Toes Pain/Tingling	Y P N F
Spasms	Y P N F

Patient's Signature: _____

NERVE SYMPTOMS

Fainting Y P N F
 Seizures, convulsions Y P N F
 Paralysis Y P N F
 Weakness Y P N F
 Numbness/Tingling Y P N F
 Dropping things Y P N F
 Tripping Y P N F

EMOTIONAL SYMPTOMS

Depression Y P N F
 Anxiety Y P N F
 Mood Swings Y P N F
 Memory Loss Y P N F
 Difficulty Sleeping Y P N F
 Fear of driving Y P N F
 Nightmares Y P N F
 Flashbacks Y P N F
 Claustrophobic Y P N F

OTHER SYMPTOMS/DISEASES

New Lumps/Bumps Y P N F
 Easy Bleeding/Bruising Y P N F
 Fevers/Chills Y P N F
 Night Sweats Y P N F
 Weight loss/gain Y P N F
 Thyroid Disorders Y P N F
 Sexually Transmitted Disease Y P N F
 Anemia Y P N F
 Diabetes Y P N F
 Cancer Y P N F
 (type) _____
 HIV Y P N F
 Hepatitis Y P N F
 Scarlet Fever Y P N F
 Rheumatic Fever Y P N F
 Diphtheria Y P N F
 Mumps Y P N F
 Measles Y P N F

HEART SYMPTOMS

Heart Disease Y P N F
 Angina Y P N F
 Swelling of legs/feet Y P N F
 Palpitations Y P N F
 Chest Pain Y P N F
 High Blood Pressure Y P N F
 Murmur Y P N F

SOCIAL HISTORY

Do you live alone? Yes No

Do You Exercise? Daily Weekly
 Monthly Rarely Never

What Type of Exercise:

History of Substance Abuse?

Yes No

What? _____

Do you smoke cigarettes now?

Yes No

If Yes, How much? _____

Packs per day for _____ years

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

Do you drink alcoholic beverages?

Yes No

If Yes, what and how

often? _____

Please list any surgeries and the dates they were performed:

Provider Signature: _____

Patient's Signature: _____