Confidential Medical History/Evaluation

Account #:_____

Name:_____ Date:_____/_____/_____ Referring Doctor:_____

Address:_____

Work Address:_____

Date of Birth:_____/_____/_____ Phone: ( )_____ SS#: _____

Insurance Company:_____ Subscriber ID: _____ Group #: _____

Insured Employer/ Address:_____ Phone: ( )_____

Occupation:_____ Is this injury: Work Related Auto Accident

Chief Complaint:_____ Date of Injury:_____/_____/_____

Current Symptoms: (please circle) Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking:_____

List any surgeries:_____

Have you had Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other:_____

Do you have any of the following?			**Pain when performing the following activities?**				
Please X Yes or No	YES	NO		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			Change Position (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				
Infectious Disease			Lifting				
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?			Recreation Activites				

Smoking Daily_____ Weekly_____ Exercise Daily Daily_____ Weekly_____

Alcohol Consumption Daily_____ Weekly_____

Other Medical Conditions:_____

Are you aware of you Diagnosis? YES_____ NO_____ Are you aware of your Progosis? YES____ NO_____

I hearby 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 covererd 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 to _____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:_____