Our Multispecialty Team Welcomes You!

You may see these names listed on your Explanation of Benefits from your health insurance carrier. Questions? Contact your assigned account representative.
Who may we thank for referring you to our office?  

☐ Medical physician

☐ Chiropractor

☐ Family or friend

☐ Internet

☐ Insurance company

PATIENT INFORMATION (Please complete all fields. If it does not apply or you do not want to provide, please write NA)

Last name_____________________ First name_____________ Middle initial____ Birthdate ______________Age_____

Street address______________________________________________________________Apt #__________________

City_________________________________________State_______________ Zip code_________________________

Home  (_____)____________Cell  (_____)__________Alt/work  (____)_________Email__________________________

Driver’s license_______________________________ SS #_______________________________ Male/Female_______

Marital status:  

☐ Single

☐ Divorced

☐ Widowed

☐ Partner

☐ Married. Name of spouse _______________________

Race___________________ Ethnicity__________________ Primary Language________________________________

Employer__________________________________________________ Occupation_____________________________

Emergency contact ________________________Relationship_______________ Phone (_______)_________________

WHO IS YOUR PRIMARY CARE PHYSICIAN? __________________________________________________________

Address________________________ City / State / Zip _______________________Phone (_______)_______________

ARE YOUR SYMPTOMS RELATED TO AN ACCIDENT?  

☐ Yes  ☐ No  ☐ Don’t know. Date of accident ____________

If yes, what type?  

☐ Auto  ☐ On the job  ☐ Other _________________________ Date reported__________________

Is there an open claim related to this injury?  

☐ No  ☐ Yes  ☐ State in which accident occurred____________

APPOINTMENTS

We ask that our patients come to their appointments 15 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT

I authorize the staff at “the Practice” to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize “the Practice” and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of “the Practice,” which describes the Practices’ policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

Print Name __________________________ Signature __________________________ Date ______________
Date: ___________________  DOB ___________________

Last name__________________________________ First name __________________________________

Who referred you to our practice? __________________________________________________________

Who is your Primary Care Physician? _______________________________________________________

Phone # _________________________________ Last visit ________________________________

List other physicians you have seen regarding your condition (specifically include any Rheumatologists, Neurologists, Orthopedic Surgeons, Spine Surgeons, or Chiropractic Physicians) ____________________________________________________________

Main pain complaint(s)                      Date started                     Pain scale (0-10)
1. ______________________________________  ______________  __________
2. ______________________________________  ______________  __________
3. ______________________________________  ______________  __________

Check whether you have had these treatments Approx last treatment Approx relief %
Chiropractic treatment  ○ Y  ○ N  __________________    __________
Physical therapy  ○ Y  ○ N  __________________    __________
Massage therapy  ○ Y  ○ N  __________________    __________
Psychology for pain  ○ Y  ○ N  __________________    __________

Check whether you have had these injections Approx date Relief
Epidural Steroid Injection  ○ Y  ○ N  __________________  ○ Y  ○ N
Facet Joint Injection or facet block  ○ Y  ○ N  __________________  ○ Y  ○ N
Radiofrequency Ablation  ○ Y  ○ N  __________________  ○ Y  ○ N
Trigger Point Injection  ○ Y  ○ N  __________________  ○ Y  ○ N

PLEASE INDICATE IF YOU HAD, OR CURRENTLY HAVE, THE FOLLOWING MEDICAL PROBLEMS:

<table>
<thead>
<tr>
<th>Heart</th>
<th>High Blood Pressure</th>
<th>Pacemaker/defibrillator</th>
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<tbody>
<tr>
<td>Bleeding or blood disorder</td>
<td>Lungs/Shortness of Breath</td>
<td>Sleep Apnea</td>
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<td>Kidney/Genitourinary</td>
<td>Bladder/Bowel incontinence</td>
<td>Stomach/Intestine/Acid reflux</td>
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<td>Nausea/Vomiting</td>
<td>Diabetes</td>
<td>Thyroid or another hormone</td>
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<td>Liver</td>
<td>Hepatitis</td>
<td>HIV</td>
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<tr>
<td>Cancer</td>
<td>Headache</td>
<td>Stroke/TIA/paralysis</td>
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<td>Seizure</td>
<td>Fracture</td>
<td>Osteoporosis</td>
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<tr>
<td>Joint/Muscle/Rheumatoid/Gout</td>
<td>Skin Disorder</td>
<td>Depression/Anxiety/other</td>
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<td>Suicidal ideation/attempt</td>
<td>Fever recent/current</td>
<td>Other</td>
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If yes to any of the above please explain and provide approximate date: ________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Height___________ Weight___________ BP ___________ Pulse ___________
Family History
Mother: Alive or Deceased ___________ Her medical conditions ________________________________________________
Father: Alive or Deceased ___________ His medical conditions ________________________________________________

Do you smoke? ______________________________ Do you drink alcohol? ______________________________

List any diagnostic tests you have had for this condition (MRIs, X-Rays, CT Scans, EMGs, etc.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Body Part</th>
<th>Facility</th>
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List all surgeries for brain, spine, joint, muscle and nerve (or any other major surgeries)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Do you have allergies to latex, adhesive tape, contrast dye, iodine/shellfish or medications?
Please list the allergy and the reaction. ________________________________________________________________

Have you had any problems with surgery or anesthesia?
Date/Reaction: ____________________________________________________________

Is there anything else in your past medical history that you feel is important to your care here?
________________________________________________________________________________________________

Pharmacy Name: __________________________ Phone # __________________________ Street: __________________________

Current medications

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<tr>
<th>Name</th>
<th>Strength</th>
<th>Take</th>
<th>Route</th>
<th>Frequency</th>
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______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Mark each box that applies

Male ☐ Female ☐
Are you under the age of 45? Yes ☐ No ☐

Is there any family history of substance abuse?
   Alcohol ☐ Yes ☐ No ☐
   Illegal Drugs ☐ Yes ☐ No ☐
   Prescription Drugs ☐ Yes ☐ No ☐

Do you have personal history of substance abuse?
   Alcohol ☐ Yes ☐ No ☐
   Illegal Drugs ☐ Yes ☐ No ☐
   Prescription Drugs ☐ Yes ☐ No ☐

Do you have a history of being sexually abused? Yes ☐ No ☐

Do you have any of the following psychological diagnoses?
   ADD, OCD, bipolar, schizophrenia? Yes ☐ No ☐
   Depression? Yes ☐ No ☐

Signature_________________________ Date_________________