

# WELCOME TO OUR OFFICE

## About You

Today's Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
CITY STATE ZIP

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long?: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

CITY STATE ZIP  
Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do You Have Children?  Yes  No How Many? \_\_\_\_\_

### Account Information (Person ultimately responsible for account)

Check if information is same as above

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS#: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Payment Method:  Cash  Check  Credit Card

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).  
INITIALS \_\_\_\_\_

### IN EVENT OF EMERGENCY

Whom should we contact?: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Who is your Medical Doctor?: \_\_\_\_\_ Phone #: \_\_\_\_\_

- ❖ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection your account.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

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

## WORK RELATED ACCIDENT

Date & Time of Accident: \_\_\_\_\_  AM  PM

Was your accident directly related to work?  Yes  No

Briefly describe the events that occurred just before and during your accident:

\_\_\_\_\_

Give the address where accident occurred: (if other than employer's address)

\_\_\_\_\_

CITY

STATE

ZIP

Was anyone else present during your accident?  Yes  No

Did you report your accident to your employer?  Yes  No

What recommendations did your employer make just after your accident? \_\_\_\_\_

Has this type of accident happened to you before?  Yes  No

To the best of your knowledge, has this accident occurred in your workplace before?  Yes  No

In general: Is your job physically stressful?  Yes  No

Is your job mentally stressful?  Yes  No

Is your workplace noisy?  Yes  No

Have you changed jobs in the last year?  Yes  No

## AFTER INJURY

Did accident render you unconscious?  Yes  No If yes, for how long?: \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

Have you gone to a hospital or seen any other doctor?  Yes  No

When did you go?  Just after the accident  The next day  2 days plus

How did you get there?  Ambulance or  Private transportation

Name of hospital and/or attending doctor: \_\_\_\_\_

Was he/she a:  D.C.  M.D.  D.O.  D.D.S.

Describe any treatment you received: \_\_\_\_\_

Were x-rays taken?:  Yes  No Were medications prescribed?:  Yes  No

Have you been able to work since this injury?:  Yes  No

Are your work activities restricted as a result of this injury?:  Yes  No

Indicate the symptoms that are a result of this accident:

Dizziness  Difficulty Sleeping  Jaw problems  Nausea  Memory loss  Irritability  Arms/Shoulder pain

Back pain  Headache(s)  Fatigue  Numb Hands/Fingers  Lower back pain  Blurred vision  Tension

Chest pain  Back stiffness  Buzzing in ear  Neck pain  Shortness of breath  Leg pain  Ears ringing

Neck Stiff  Stomach Upset  Numb feet/toes  Other \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes & Goes

## RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? \_\_\_\_\_

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

Standing  Sitting  Walking  Lifting  Driving  Twisting  Crawling  Bending  Operating equipment

Work with arms above head  Typing  Stooping  Other \_\_\_\_\_

What positions can you work in with minimum physical effort and for how long? \_\_\_\_\_  N/A

Prior to the injury were you capable of working on an equal basis with others your age?  Yes  No  N/A

Do you work with others who can help you with any heavy lifting?  Yes  No  N/A

While in recovery, is there any light duty work you could request?  Yes  No  N/A

## PAST MEDICAL HISTORY

Place an (x) if it applies and describe.

- None related to current complaints  Hospital or operation  Auto Accident  Work Accident  Illness  
 Other
- 
- 

## FAMILY HISTORY

Place an (x) if any family member has suffered from:

- Tuberculosis  Kidney Disease  Spinal Disorder  Mental Illness  Epilepsy  Diabetes  Gout  
 Allergy  Arthritis  Hypertension  Cancer  Migraines  Heart Attack  Other, list: \_\_\_\_\_

## PERSONAL HISTORY

Do you take supplements or vitamins?  Yes  No Do you exercise?  No  Yes \_\_\_\_\_ hours per week

Do you smoke?  No  Yes How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing:  Shoe lifts  Inner soles  Arch supports Are you dieting?  No  Yes Since \_\_\_\_\_

For women: Are you pregnant?  Yes  No  Not Sure Are you taking birth control?  Yes  No

Are you nursing?  Yes  No

Medications: \_\_\_\_\_

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Disease: \_\_\_\_\_

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Other: \_\_\_\_\_

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## SYSTEM REVIEW

Check all that apply. If none apply please select N/A:

**Genito-Urinary System**  N/A

- Bladder trouble  Excessive urination  Scant urination  Painful urination  Discolored urine

**Gastro-Intestinal System:**  N/A

- Poor appetite  Excessive hunger  Difficult chewing  Difficult swallowing  Excessive thirst  Nausea  
 Vomiting food  Abdominal pain  Diarrhea  Constipation  Black stool  Bloody stool  Hemorrhoids  
 Liver trouble  Weight trouble  Gall bladder trouble

**Nervous System:**  N/A

- Numbness  Loss of feeling  Paralysis  Dizziness  Fainting  Headaches  Muscle jerking  
 Convulsions  Forgetfulness  Confusion  Depression

**Cardio-vascular System:**  N/A

- Chest pain  Pain over heart  Difficult breathing  Persistent cough  Coughing blood  
 Coughing phlegm  Rapid heartbeat  High blood pressure  Heart problems  Lung problems  
 Varicose veins  Other \_\_\_\_\_

**Eyes, Ears, Nose and Throat System:**  N/A

- Eye strain  Eye inflammation  Vision problems  Ear pain  Ear noises  Ear discharge  Hearing loss  
 Breathing difficulty  Nose bleeding  Nose discharge  Sore gums  Nose pain  Sore mouth  
 Sore throat  Hoarseness  Speech difficulty  Dental problems

Please continue on back...

## ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

### Section 1: Pain Intensity

- I can tolerate the pain I have without using pain killers.
- Pain killers give me complete relief from pain.
- The pain is bad but I manage without taking pain killers.
- Pain killers give me moderate relief from pain.
- Pain killers give me very little relief from pain.
- Pain killers give no relief from pain. I do not use them.

### Section 2: Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in the most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

### Section 3: Lifting

- I can lift heavy weights without causing extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- I can lift only very light weights.
- Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned.
- I cannot lift or carry anything at all.
- I can lift heavy weights but it causes extra pain.

### Section 4: Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Section 5: Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting for more than 30 minutes.

### Section 6: Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it causes extra pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### Section 7: Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Pain prevents me from sleeping at all.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.

### Section 8: Sex life

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### Section 9: Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.)
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

### Section 10: Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary trips under a ½ hour.
- Pain restricts me from traveling except to the doctor or hospital.