

Confidential Medical History/Evaluation

Name: _____ Date: ____/____/____ Referring MD: _____

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: _____ Onset Date: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

List any surgeries: _____

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

Do you have any of the following?			Pain when performing the following activities?				
	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 Pos (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?	_____	_____	Recreational Activities	_____	_____	_____	_____
Smoking	Daily _____	Weekly _____	Exercise	Daily _____	Weekly _____		
Alcohol Consumption	Daily _____	Weekly _____					

Other Medical Conditions _____

Are you aware of your Diagnosis? YES ___ NO ___ Are you aware of your Prognosis? YES ___ NO ___

I hereby 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 covered 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 directly 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: _____