Patient Information and History

PATIENT INFORMATION

Date____________ Home Phone________________________

Name____
LAST NAME *FIRST NAME* *INITIAL*

Address____

____

<u>Sex</u> M F Age_________Birthdate_______________

SS#__________________________Marital Status___________

Occupation ____

Employer____

Phone:____________________ Email:______________________
○ (check if primary contact) ○

<u>Tobacco Use:</u>
○ Never ○ Current every day ○ Current sometimes ○ Former

Spouse's Name____
Does your spouse have permission to access
your medical records? ○ Yes_____ ○ No______
Initial Initial

Whom may we thank
for referring you?______________________________________

<u>IN CASE OF EMERGENCY, CONTACT</u>:

Name________________________Relationship_______________

Home Phone________________Work Phone________________

INSURANCE

Do you have Medicare? Yes No

Primary Insurance Co.______________________________________

Secondary Insurance Co._____________________________________

Is patient covered by any additional insurance? Yes No

<u>ASSIGNMENT AND RELEASE</u>
I, the undersigned certify that I (or my dependent) have insurance coverage with__________________________________ and assign directly to Virginia Sport & Spine Institute LLC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance as well as interest of 1.5% per month, attorney's fees, collection agency fees and costs associated with the collection of overdue balances. I hereby Cell authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Patient / Guardian Signature

______________________________________ ___________________
Relationship Date

<u>Is condition due to an accident</u>? Yes No

Date of accident________________ In which state?______________
<u>Type of accident</u> Auto Work Home Other_______________

<u>To whom have you made a report of your accident</u>?

Auto insurance Employer Worker Comp. Other

Attorney Name (if applicable)_________________________________

PATIENT CONDITION

Reason for visit____ When did your symptoms appear?____________________________

<u>Is this condition getting progressively worse</u>? Yes No Unknown How often do you have this pain?________________________

<u>Is your pain</u>? Constant <u>or does it</u>? Come and go <u>Does it interfere with your</u>? Work Sleep Daily Routine Recreation

<u>Activities that are painful to perform</u>? Sitting Standing Walking Bending Lying Down

<u>Indicate on the diagram the type of pain using the symbols below</u>.

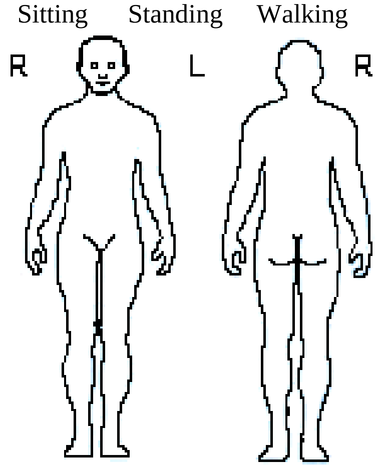
Ache : ZZZ

Burning : BBB

Numb : XXX

Pins & Needles : = = =

Stabbing : ///



List each area of pain (IE. Neck or Back)	**How severe is your pain today?** 0 = No Pain 10 = Intolerable
____________________	_________
____________________	_________
____________________	_________
____________________	_________
____________________	_________

Patient Information and History (continued) **Print Name:**_______________________________

Primary Care Physician _____________________________ Specialist ________________________________ Type___________

Date of Last: Physical Exam_______________ Spinal X-Ray_______________ Spinal Exam_______________
(If none, write N/A)

Blood Test__________________ Chest X-Ray________________ Urine Test________________

Dental X-Ray________________ MRI/CT-Scan/Bone Scan______________ Bone Density_______________

Circle any treatments have you already received for the condition you are being seen for today?

(Medications) (Surgery) (Physical Therapy) (Chiropractic) (Injections) Other _____________________________________

Please circle symptoms you currently have:

Dizziness/Loss of Balance	Loss of Memory	Ringing/Buzzing in Ears	Depression	Nausea
Visual/Sensory Disturbance	Lightheadedness	Loss of Concentration	Headaches	Burning Eyes

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Hernia	□ Neuritis	□ Cancer
□ Disc Bulge	□ Pinched Nerve	□Whiplash

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

EXERCISE		**WORK ACTIVITY**		**LIFESTYLE**	
None	Daily	Sitting	Light Labor	Smoking Packs/Day______	Coffee/Caffeine (Cups/Day_____)
Moderate	Heavy	Standing	Heavy Labor	Alcohol Drinks/Week____	High Stress Level (Reason________)

INJURIES/SURGERIES YOU HAVE HAD

(If none, write N/A)	(Description)	(Date)
Falls	___________________________________	_________
Head Injuries	___________________________________	_________
Broken Bones	___________________________________	_________
Dislocations	___________________________________	_________
Surgeries	___________________________________	_________

Please list below anything you are currently taking.

MEDICATIONS (start date)	**VITAMINS/HERBS**
___________________	____________________
___________________	____________________
___________________	____________________
___________________	____________________
___________________	____________________

ALLERGIES: ○ If none check____

I authorize the release of my medical records to: ________________________ _______________ ________________________ _________________

Name Relation Name Relation

I have read, understood, and agree to the foregoing. I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this clinic responsible for any errors or omissions that I may have made in the completion of this form. I understand that the doctor will be relying on the above information and all other information that I supply in his treatment of me. I hereby give permission to the doctor and whomever he may designate as his assistants to administer treatment and/or therapy, and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition. I certify that no guarantee has been made as to the results that may be obtained.

Patient / Guardian Signature____ **Date**________________________

For Office Use:

HT: _______ft_______in Wt:___________(lbs) BP: ________/________ HR: ________bpm