Patient Information and History

PATIENT INFORMATION

Date_____ Home Phone_____

Name _____
LAST NAME *FIRST NAME* *INITIAL*

Address_____

_____

Sex M F Age_____ Birthdate _____

SS# _____ Marital Status _____

Occupation _____

Employer _____

Cell Phone : _____Email: _____
○ (check if primary contact)

Tobacco Use
○ 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?

_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship _____

Home Phone _____ Work Phone _____

INSURANCE

Do you have Medicare? Yes No

Primary Insurance Co. _____

_____ _____
Insurance Holder's Name **Date of Birth**

Secondary Insurance Co._____

Is patient covered by any additional insurance? Yes No

_____

ASSIGNMENT AND RELEASE

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 hereby 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 Date

_____
Relationship

Is condition due to an accident? Yes No

Date of accident_____ In which state?_____

Type of accident Auto Work Home Other _____

To whom have you made a report of your accident?
Auto insurance Employer Worker Comp.
Other _____

Attorney Name (if applicable)_____

PATIENT CONDITION

Reason for visit_____ When did your symptoms appear?_____

Is this condition getting progressively worse? Yes No Unknown How often do you have this pain?_____

Is your pain? Constant or Come & Go Does it interfere with your? Work Sleep Daily Routine Recreation

Activities that are painful to perform? Sitting Standing Walking Bending Lying Down

Indicate on the diagram the type of pain using the symbols below.

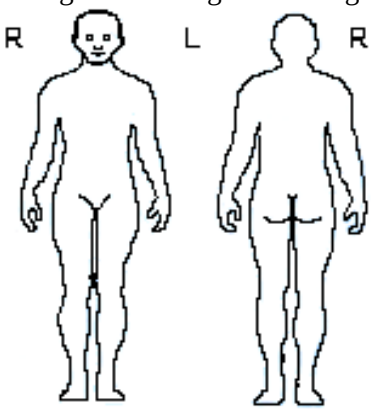
Ache: ZZZ

Burning: BBB

Numb: XXX

Pins & Needles : = = =

Stabbing: ///



List each area of pain (IE. Neck or Back)	How sever is your pain today? 0= No Pain 10= Intolerable
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use: HT: _____ft_____in Wt:_____(lbs) BP: _____/_____ HR. _____BPM

Primary Care Physician _____ Specialist _____Type_____

Date of Last: (If none, write N/A)

Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____

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
None Daily
Moderate Heavy

WORK ACTIVITY
Sitting Light Labor
Standing Heavy Labor

LIFESTYLE
Smoking Packs/Day _____ Coffee/Caffeine (Cups/Day _____)
Alcohol Drinks/Week _____ High Stress Level (Reason _____)

INJURIES/ SURGERIES YOU HAVE HAD

(If none, write N/A)	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bone	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Please list below anything you are currently taking.

MEDICATION (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_____