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: _____

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

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?_____

Since onset, how do you feel? The same Better Worse

How often do you have this pain? Occasional Intermittent Frequent Constant

What Aggravates your pain? Sleeping Working Sitting Standing Walking Bending Lying down Carrying Lifting

What Helps it feel better? Nothing Anti-inflammatories Bracing Movement Heat Ice Massage Stretching Rest

Activities that are painful to perform? Working Social/recreational Housework Grooming Driving Exercising

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

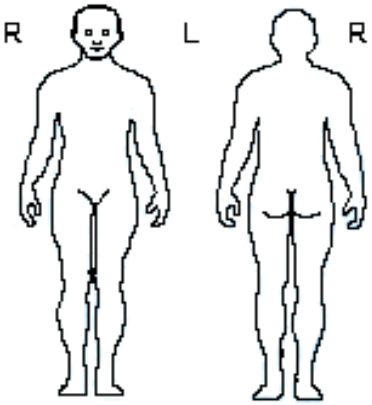
Ache: ZZZ

Burning: BBB

Numb: XXX

Pins & Needles: = = =

Stabbing: ///



List each area of pain (IE. Neck or Back)	How severe 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 Check the Following symptoms you current HAVE, HAD in the past, or NO to those you have not had:

Have	Had	No		Have	Had	No		Have	Had	No	
			Back pain				Irregular heartbeat				Easily angered or irritated
			Muscle or joint pain				Palpitations				Fainting
			Neck pain				Persistent coughing				Neuralgia
			Redness of joints				Shortness of breath				Numbness
			Stiffness				Tightness in chest				Seizures
			Swelling of joints				Facial Pain Griding teeth				Weakness
			Chest pain				Headaches				Anxiety
			Difficulty breathing				Migraines				Depression
			Dizziness/lightheaded				Head injury				Memory loss
			Fainting				Jaw clicks				Nervousness
							Stiffness				Stress

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, VITAMINS/HERBS (include Dosage)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: ○ If none check _____

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**_____