HEMINGWAY SPINAL CARE CENTER

DR. MARIE S. CURTIS, DC ▪ HEMINGWAY SPINAL CARE CENTER ▪ 304 E. BROAD ST. ▪ PO Box 1601 ▪ HEMINGWAY, SC 29554 ▪ 843/558-0056

Personal Information

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Dr.

Patient Name _____ **Date** _____
Last First Mi

Mailing Address _____
Street City State Zip

Phone _____ | _____ | _____
Home Cell Work

Age _____ **Date of Birth** _____ | _____ | _____ **Sex** ☐ Male ☐ Female **No. of Children** _____
Mo. Day Year

Social Security # _____ | _____ | _____ **Status** ☐ Divorced ☐ Widowed ☐ Married ☐ Single

Occupation _____ **Employer** _____ **Years Employed** _____

Work (Ph) _____ **Address** _____
City/State

Spouse _____ **Occupation** _____ **Employer** _____

Person Responsible for This Account _____

Health Questionnaire

Reason for Visit _____

When did your symptoms appear? _____

Rate the severity of your pain on a scale of 0 (No Pain) to 10 (Severe Pain)? (Circle a No.)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Severe Pain

How often are your symptoms present? ☐ Intermittently ☐ Occasionally ☐ Frequently ☐ Constantly

Describe your current symptoms. ☐ Soreness ☐ Throbbing ☐ Aching ☐ Dull ☐ Sharp/Stabbing ☐ Weakness ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Other _____

What makes the problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Other _____

What makes the problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Other _____

Can you perform your daily home activities? ☐ Yes ☐ Yes, with help ☐ Not at all

Do you exercise? ☐ Yes, almost daily ☐ Yes, occasionally ☐ Not at all

Describe your job requirements. ☐ Mainly Sitting ☐ Mainly Standing ☐ Light labor ☐ Heavy Labor

Can you perform your daily work activities? ☐ Yes, all activities ☐ Only some ☐ Not at all

Describe your stress level. ☐ None to mild ☐ Moderate ☐ High

What treatments have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____

Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

Do you have a pacemaker, infusion pump, defibrillator, or any other similar device? ☐ **No** ☐ **Yes**

If yes explain: _____

Hospitalizations/Surgical Procedures _____

Current Medications _____

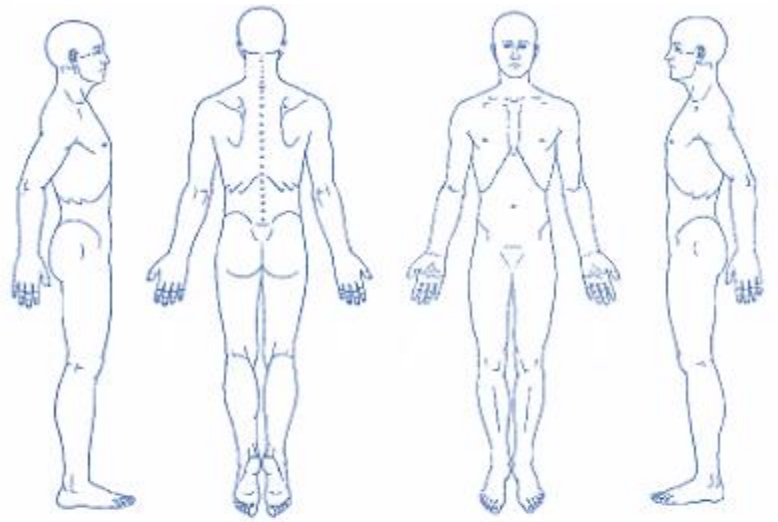
Do you have a permanent disability rating? ☐ Yes ☐ No **Location** _____

Rating percentage _____ **%** **Date rating received** _____ | _____ | _____
Mo. Day Year

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain)

Numbness	N
Pins & Needles	P
Burning	B
Aching	A
Stabbing	S
Cramping	C

Right Back Front Left



Medical History

Knowledge of these conditions may influence the type of treatment/therapy you receive.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
☐	☐	Neck Pain	☐	☐	Incontinence	☐	☐	Epilepsy
☐	☐	Shoulder Pain ( )R ( )L	☐	☐	Constipation	☐	☐	Fainting
☐	☐	Upper Arm Pain ( )R ( )L	☐	☐	Irritable Colon	☐	☐	Chronic Sinusitis
☐	☐	Elbow Pain ( )R ( )L	☐	☐	Colitis	☐	☐	Difficulty Swallowing
☐	☐	Hand Pain ( )R ( )L	☐	☐	Abdominal Pain	☐	☐	Diabetes
☐	☐	Wrist Pain ( )R ( )L	☐	☐	Ulcer	☐	☐	Headache
☐	☐	Upper Back Pain	☐	☐	Heartburn/Indigestion	☐	☐	Jaw Pain
☐	☐	Lower Back Pain	☐	☐	Angina	☐	☐	Tinnitus (ear noises)
☐	☐	Hip Pain ( )R ( )L	☐	☐	Heart Attack (Date)_____	☐	☐	Visual Disturbances
☐	☐	Knee Pain ( )R ( )L	☐	☐	Aortic Aneurysm	☐	☐	Vertigo/Dizziness
☐	☐	Lower Leg Pain ( )R ( )L	☐	☐	Chest Pains	☐	☐	Drug of Alcohol Dependence
☐	☐	Foot Pain ( )R ( )L	☐	☐	High Blood Pressure	☐	☐	Loss of Appetite
☐	☐	General Fatigue	☐	☐	Rapid Heart Beat	☐	☐	Abnormal Weight Gain
☐	☐	Depression	☐	☐	Stroke (Date)_____	☐	☐	Abnormal Weight Loss
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Anorexia/ Bulimia
☐	☐	Emphysema	☐	☐	Liver/Gallbladder Problems	☐	☐	HIV/AIDS
☐	☐	Chronic Cough	☐	☐	Prostate Problems	☐	☐	Tumor, Explain_____
☐	☐	Arthritis	☐	☐	Kidney Stones	☐	☐	_____ _____
☐	☐	Rheumatoid Arthritis	☐	☐	Muscular Incoordination	☐	☐	Cancer, Explain_____
☐	☐	Swelling/stiffness of joints	☐	☐	Endometriosis	☐	☐	_____ _____

Family History

If a family member had had any of the following, please mark the appropriate box:

☐ Cancer Family Member_____

☐ Chronic Back Problems Family Member_____

☐ Chronic Headaches Family Member_____

☐ Diabetes Family Member_____

☐ Heart Problems Family Member_____

☐ High Blood Pressure Family Member_____

☐ Lung Problems Family Member_____

☐ Lupus Family Member_____

☐ Rheumatoid Arthritis Family Member_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature **Date**