St. Pete Spinal Care
Patient Information & History

1 PATIENT INFORMATION

Name: ____
(First) (Initial) (Last) (Name called by)
Address: ___________________________________
____
Birthday: ___________ Age: ___ Male Female
Social Security # _______/______/______
Occupation: _________________________________
Employer: __________________________________
Parents Name(if a minor):___________________
Single Married Divorced Widowed Seperated
Spouse's Name: ______________________________
# of Children:_______ Name(s) _______________
Referred By_________________________________

2 INSURANCE

Who is responsible for this account?__________
Relationship to patient__________________
Insurance company______________________
Insurance ID number____________________
Group / Claim number___________________
Is patient covered by additional insurance? Yes No
Insurance company______________________
Subscriber # and name__________________
Birthdate__________Group #____________
Please present insurance card(s) so we can put a copy in your file

3 CONTACT INFORMATION

Home phone__________________________
Cell phone____________________________
Work Phone___________________Ext______
Email________________________________
Best way to reach you Home Cell Work Email
IN CASE OF EMERGENCY, CONTACT
Name_______________Relationship______
Home Phone______________Cell____________

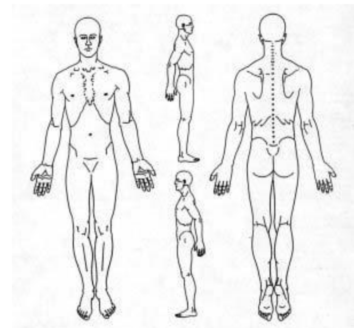
4 ACCIDENT INFORMATION

Is your condition due to an accident? □No □Yes
Date: _______________________________
Type of accident? □Automobile □Work □Home
□Other____________________________________
To whom have you reported the accident?
____
□Insurance □Worker's Comp □Employer □
Other_____________________________________
Attorney Name (If applicable)
____

5 PATIENT CONDITION

What is your major symptom/problem? _________________________
When did your symptoms begin? _________________________________
Have you had this problem before? _______________________________
Is your condition getting progressively worse? □ Yes □ No
Is this problem: □ constant □ comes and goes
How does it Feel? □Burning □Sharp□ Shooting □Dull□ Aching □Stiff
□Tingling □Throbbing □Swelling□ Other___________________
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)
What makes your condition better? _____________________________
What makes your condition worse? _____________________________
Does it interfere with your □Work □Sleep □Daily Routine □Recreation
Activities/movements that are painful to perform:
□Sitting □Standing □Walking□ Bending□ Lying down □Driving□ Reading□ Getting Up

Please mark where it hurts



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HEALTH HISTORY

What other treatments have you had for this condition?

□Chiropractic □Orthopedic □Neurologist □Physical Therapy □Medication □Surgery

Name of other doctors who have treated you for this condition ________________________________

Describe the other doctor's treatment for your condition______________________________________

Previous Chiropractic care? □No □Yes Date___________ □Local □Out of state

Date of Last: Physical Exam___________ Spinal x-ray___________ MRI ___________

Spinal Exam ___________ Dental x-ray___________ CT- Scan ___________

List any Medications you are taking____

Vitamins / Herbs / Minerals

____

Females: Are you Pregnant? □Yes □No Beginning of last menstrual cycle_________________

Check any of the following conditions you have had:

□AIDS/HIV	□Ear ringing	□Neck pain
□Allergies	□Epilepsy	□Osteoporosis
□Anxiety/Depression	□Headaches	□Poor circulation
□Arm/shoulder pain	□Headaches - Migraine	□Prostate problems
□Arthritis	□Heart Disease	□Rheumatoid Arthritis
□Asthma	□Hemorrhoids	□Sciatica
□Bladder problems	□Herniated disk	□Shingles
□Cancer	□High blood pressure	□Sinus infection
□Chronic fatigue	□Insomnia	□Stroke
□Deafness	□Irregular cycle	□Thyroid problems
□Diabetes	□Kidney problems	□TMJ
□Digestion problems	□Leg pain	□Venereal disease
□Earache	□Low back pain	□Vertigo/Dizziness

STRESSORS		**EXERCISE**
□Smoking	Packs/Day ________________	□None
□Alcohol	Drinks/Week ______________	□Moderate
□Coffee/ Caffeine Drinks	Cups/Day _________________	□Daily
□High Stress Level	Reason ___________________	□Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	______________________________________	______________
Surgeries	______________________________________	______________
Broken bones	______________________________________	______________
Falls/Head injuries	______________________________________	______________

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AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize St. Pete Spinal Care/ Stanley Grimmel, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

________________________________ ____________ ______________________________

Signature Date Parent (if patient is a minor)