DISCOVER soft tissue+spine

New / Returning Patient Intake Form

Please fill out all the information. We cannot begin the consultation until this form is fully completed

Date	I.D. #

Patient's Full Name: _____ Age:_____ Sex: ❑M ❑F

How would you like to be addressed by our staff? _____Date of Birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone (Home):_____(Work):_____(Cell):_____

Which phone number is your preferred method of contact: ❑ Home ❑ Work ❑ Cell

Email Address:_____ Marital Status: ❑S ❑M ❑D ❑W Number of Children: _____

I give you permission to email me appointment reminders, newsletters, birthday cards, etc. ❑Yes ❑No

Occupation: _____

Employer: _____ Driver's License Number: _____

Emergency Contact's Name: _____ Relationship:_____

Phone:_____ City: _____ State:_____ Zip: _____

Medical Doctor's Name: _____ Affiliation: ❑Spectrum ❑Metro ❑Mercy – St. Marys ❑Other: _____

Phone:_____ City: _____ State_____ Zip: _____

I give you permission to send my Medical Doctor a report regarding my diagnosis/care. ❑Yes ❑No

How did you hear about this office: _____ Referred by: _____

IF YOU HAD A MAGIC WAND, WHICH PAIN AREA WOULD YOU GET RID OF?

What ONE AREA hurts? _____

How bad is the pain
on a scale from 0-10
(0 = no pain 10 = worst pain ever)

Currently _____

On Average _____

Worst Ever _____

Please mark on the images where you are feeling the pain

When did your symptoms begin?

Date:_____

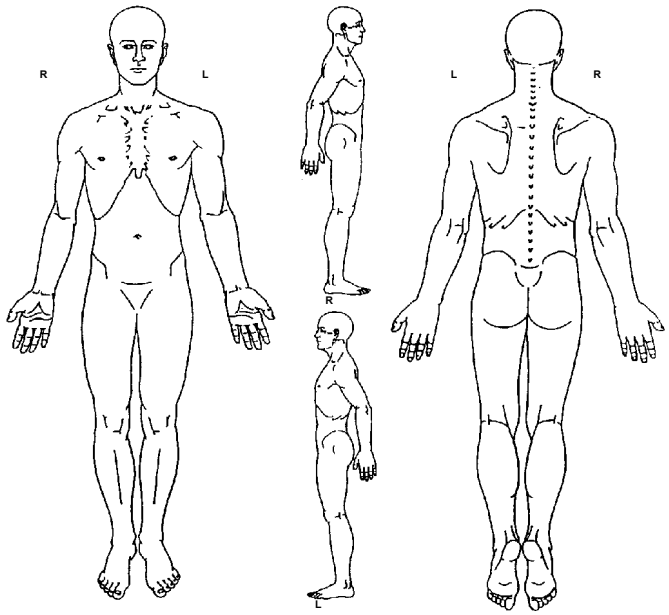
☐Immediately after a specific incident

☐After multiple incidents

☐Gradually developed over time

☐Other _____

PLEASE CIRCLE THE AREA BELOW TO INDICATE THE LOCATION OF YOUR SYMPTOMS



PLEASE CHECK WHAT SYMPTOMS ARE YOU EXPERIENCING:

- ❑ ACHING
- ❑ BURNING
- ❑ NUMBNESS/TINGLING
- ❑ PINS & NEEDLES
- ❑ STABBING
- ❑ SHARP
- ❑ STIFFNESS
- ❑ THROBBING
- ❑ OTHER _____

_____

What caused the pain: ☐no apparent cause ☐one incident_____

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

Has this pain occurred before: ☐Yes ☐No How long ago since first occurrence? _____ months / years ago

Do you feel pain sitting here, RIGHT NOW, WITHOUT MOVING, **at REST**? ☐Yes ☐No If yes, how intense is it from 0-10? _____

What makes the pain **WORSE**? _____

☐Nothing ☐Lying down ☐Standing ☐Sitting ☐Movement/Exercise ☐Other _____

How long (in mins or hours) do you have to do the above activity before it gets **WORSE**? _____

The symptoms are:

Better in the:	**Worse in the:**	**Frequency of symptoms:**	**Does it interfere with your daily activities:**
☐ first wake up	☐ first wake up	☐ Intermittent (25% or less)	☐ minimal (annoyance, no impairment)
☐ morning	☐ morning	☐ Occasional (26 – 50%)	☐ slight (tolerated, some impairment)
☐ afternoon	☐ afternoon	☐ Frequent (51 – 75%)	☐ moderate (marked impairment)
☐ evening	☐ evening	☐ Constant (76 – 100%)	☐ severe (preclude any activity)
☐ nighttime	☐ nighttime		
☐ none	☐ none		

If you feel it more in the morning, **how much time** does it take until it gets better? _____

What activities are you prevented from performing due to your pain? _____

_

What makes the pain feel **BETTER**?_____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

What is your BIGGEST concern about your pain? _____

Is there anything else I should know? _____

Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other:_____

What type of physical activity do you do? ☐Weights ☐CrossFit ☐Walking ☐Running ☐Spinning ☐Yoga ☐Other_____

How many days per week do you exercise? _____

What is your athletic history (middle, high school, college, post-college)? _____

Secondary or related complaint(s) if any: _____

PAST INJURY/DISEASE HISTORY

Have you been treated for your CURRENT problem in the past? ☐Yes ☐No

If yes, when: _____ If yes, by whom: _____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

Have you been treated for **OTHER** (back pain, neck pain, etc.) problems in the past? ☐Yes ☐No

If yes, when: _____ If yes, by whom: _____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents (sports or auto), or surgeries:

DATE	Injury / Fracture / Illness / Surgery / Fall	Treatment	Result

What is your current work status?

❑Full time, no restrictions ❑Full time, restrictions ❑Full time Homemaker ❑Full time student ❑Part time, no restrictions
❑Part time, restrictions ❑Retired ❑Unemployed ❑Off work due to restrictions ❑Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ❑Yes ❑No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

Are you presently taking **any medication, prescription, over-the-counter, home remedies, vitamins, minerals**, etc? (Please list)

Please check the box for each item below you have had, or currently have, with approximate dates.

DATE	MUSCULO-SKELETAL	DATE	CARDIO-VASCULAR	DATE	SKIN OR ALLERGIES	DATE	GENERAL SYMPTOMS
_____	❑ Painful Joints	_____	❑ High Blood Pressure	_____	❑ Bruising Easily	_____	❑ Allergy (what)
Where_____		_____	❑ Low Blood Pressure	_____	❑ Dryness		_____
_____	❑ Osteoporosis	_____	❑ Heart Disease	_____	❑ Eczema		_____
_____	❑ Muscle Spasms/Cramps	_____	❑ Chest Pain	_____	❑ Hives or Allergy	_____	❑ Loss of Sleep
Where_____		_____	❑ Poor Circulation	_____	❑ Itching	_____	❑ Chills (Constant)
_____	❑ Other	_____	❑ Rapid Heart	_____	❑ Sensitive Skin		
_____	❑ Stiff Neck	_____	❑ Slow Heart	**DATE**	**EMOTIONAL/MENTAL**	**DATE**	**RESPIRATORY**
_____	❑ Spinal Curvature	_____	❑ Strokes	_____	❑ Nervousness	_____	❑ Chest Pain
_____	❑ Swollen Joints	_____	❑ Abnormal Swelling	_____	❑ Anxiety	_____	❑ Chronic Cough
_____	❑ Arthritis Pain	_____	❑ Varicose Veins	_____	❑ Mild Depression	_____	❑ Difficulty Breathing
Where_____		_____	❑ Palpitations	_____	❑ Clinical Depression	_____	❑ Asthma
_____	❑ Scoliosis			_____	❑ Panic Attacks	_____	❑ Bronchitis

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Cont… Please check the box for each item below you have had, or currently have, with approximate dates

DATE	NEUROLOGICAL	DATE	GASTRO-INTESTINAL	DATE	NOSE/THROAT/EYE/EAR	DATE	GENITO-URINARY
_____	❑ Migraines	_____	❑ Belching	_____	❑ Impaired Hearing	_____	❑ Bed Wetting
_____	❑ Headaches	_____	❑ Colon Trouble	_____	❑ Deafness	_____	❑ Blood in Urine
_____	❑ Bell's Palsy	_____	❑ Constipation	_____	❑ Earache	_____	❑ Frequent Urination
_____	❑ Paralysis	_____	❑ Diarrhea	_____	❑ Ear Discharge	_____	❑ Inability to Control
_____	❑ Seizures	_____	❑ Gall Bladder Trouble	_____	❑ Ear Noises		Urine
_____	❑ Dizziness/Vertigo	_____	❑ Hemorrhoids (piles)	_____	❑ Thyroid Problems	_____	❑ Kidney Infection
_____	❑ Epilepsy	_____	❑ Jaundice	_____	❑ Frequent Colds	_____	❑ Kidney Stones
_____	❑ Loss of Balance	_____	❑ Liver Trouble	_____	❑ Hay Fever	_____	❑ Painful Urination
_____	❑ Numbness/Tingling	_____	❑ Nausea/Vomiting	_____	❑ Nasal Obstruction	_____	❑ Prostate Trouble
Where:		_____	❑ Stomach Pain	_____	❑ Nose Bleeds	**DATE**	**FOR FEMALES ONLY**
❑right arm ❑left arm		_____	❑ Bloating	_____	❑ Eye Pain/Strain	_____	❑ Cramps
❑right hand ❑left hand		_____	❑ Vomiting Blood	_____	❑ Impaired Vision	_____	❑ Hot Flashes
❑right leg ❑left leg		_____	❑ Heart Burn	_____	❑ Blurred Vision	_____	❑ Irregular Cycle
_____	❑ Twitching	_____	❑ Bloody Stools	_____	❑ Sinus Problems	_____	❑ Painful Periods
DATE	**Energy & Immunity**	_____	❑ Acid Reflux	_____	❑ Sore Throats	Pregnant at this Time	
_____	❑ Fatigue	_____	❑ Irritable Bowel	_____	❑ Tonsillitis	❑Yes ❑No	
_____	❑ Fatigue After Exercise	**DATE**	**Endocrine**	**DATE**	**Endocrine Cont.**	**DATE**	**Other Conditions**
_____	❑ Easy Bruising	_____	❑ Hypothyroidism	_____	❑ Night Sweats	_____	❑ Cancer
_____	❑ Frequent Flu or Cold	_____	❑ Hyperthyroidism	_____	❑ Unusual Sweating	Type: _____	
_____	❑ Chronic Infections	_____	❑ Hypoglycemia	_____	❑ Loss of Hair	_____	❑ Anemia
_____	❑ Autoimmune Disease	_____	❑ Diabetes Type I	_____	❑ Other:	_____	❑ Insomnia
_____		_____	❑ Diabetes Type II	_____		Other: _____	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? (PLEASE CHECK ANY OR ALL THAT APPLY)

❑Appendicitis	❑Hepatitis	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Leukemia	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lymphoma	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Atrial Fibrillation	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

LIFESTYLE

HABITS

❑Smoking Packs/day: _____
❑Drinking Alcohol: (Cups/day) _____
❑Recreational Drugs Amount: _____
❑Coffee Cups/Day: _____
❑Soft Drink Bottles or Cans/Day: _____
❑Water Cups/Day: _____

EXERCISE

❑None
❑Moderate
❑Daily
Type: _____
_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back	Heart
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother(s), # of ___	❑	❑	❑	❑	❑
Sister(s), # of ____	❑	❑	❑	❑	❑

Average Hours of Sleep a Night _____Hours

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. I understand that this office/provider does not participate with any insurance company except Federal Medicare. Payment is due at time of service and any amount authorized to be paid by an insurance company directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until the balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $20 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers to secure the payment of benefits.

I hereby authorize the doctor or therapist to examine and treat my condition as he/she deems appropriate, and I give authority for these procedures to be performed.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature: _____ **Date**: _____

Guardian Signature Authorizing Care: _____ **Date:** _____

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