Allied Pain and Wellness

PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

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

Birth date:____/_____/_____ Age:_____ Gender: ☐ Male or ☐ Female

Social Security #:_____-_____-_____ ☐ Married ☐ Single or ☐ Minor

Whom may we thank for referring you to us?_____

CONTACT INFORMATION

Home Phone #:(_____)_____ Cell Phone #:(_____)_____

E-mail Address:_____

PAYMENT INFORMATION

Do you have health insurance? ☐ Yes ☐ No **OR** ☐ Check if a lien, *and continue to next box*

Insurance Company Name:_____

Member Identification #:_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature:_____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No, *and continue to next page*

Date of Accident:_____/_____/_____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other_____

Do you have access to recent x-rays? ☐ No ☐ Yes, where at?_____

Attorney Name (if applicable): _____

Attorney Phone #:(_____)_____ Attorney Fax #:(_____)_____

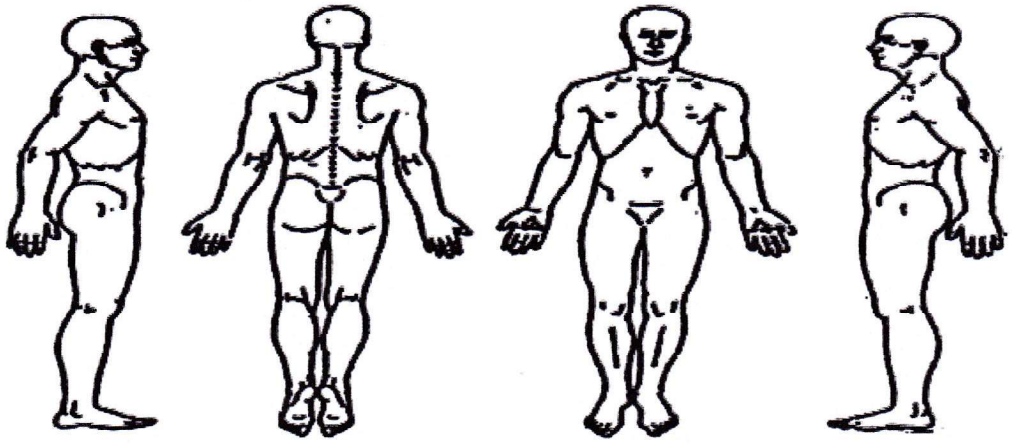
Attorney Address: _____ City_____ State_____ Zip_____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. When do you feel your pain at its worst?

Morning Afternoon Night With Activity (explain): _____

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? _____

12. How do you think your problem began?

_____

13. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

14. What aggravates your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

Does the pain travel to anywhere else in the body? _____

16. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

17. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

21. List all prescription medications you are currently taking:

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

27. Have you had significant past trauma? □ No □ Yes

28. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____