SPINAL HEALTH GROUP

Caring is the heart of our commitment

PATIENT INFORMATION

Date_____

Name_____

Street Address_____

City_____ State_____ Zip_____

Home Telephone (____) _____ SS#_____

Cell phone (____) _____ Email_____

Birth date_____ Age_____ Sex_____

○Married ○Single ○Widowed ○Divorced No.of Children_____

Present Family Doctor_____ Phone_____

Address_____

How did you hear of us?_____

EMPLOYMENT INFORMATION

Employer_____

Address_____

City _____ Zip_____

Phone # (____) _____

Occupation_____

EMERGENCY INFORMATION

Emergency Name_____

Relationship_____

Phone # (____) _____

Main reasons for contacting us: _____

When did it start? ____/____/____. It started: ○ Suddenly ○ Gradually

Is this condition getting worse? ○ Worse ○Same ○Better

Does this condition interfere with your ○ Work ○ Sleep ○ Daily activity

What seems to bring on your condition? _____

_____

What makes it feel worse?

○ Driving	○ Walking	○ Sitting
○ Bending	○ Standing	○ Sleeping
○ Breathing	○ Coughing	○ Sneezing
○ Working	○ Exercise	○ Bowel Movement
○ Other_____		

What makes it feel better?

○ Rest	○ Sitting	○ Standing
○ Ice	○ Walking	○ Lying down
○ Heat	○ Standing	○ Massage
○ Nothing	○ Meds	○ Stretching
○ Other_____		

Describe your condition:

○ Constant 100%	○ Frequent 75%	○ Intermittent 50%	○ Occasional 25%	○ Rare 10%
○ Sharp	○ Dull	○ Aching	○ Burning	○ Numb
○ Localized	○ Radiating to:_____			

Rate your pain TODAY (circle 0 for no pain to 10 unbearable) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Rate your AVERAGE pain (circle 0 for no pain to 10 unbearable) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

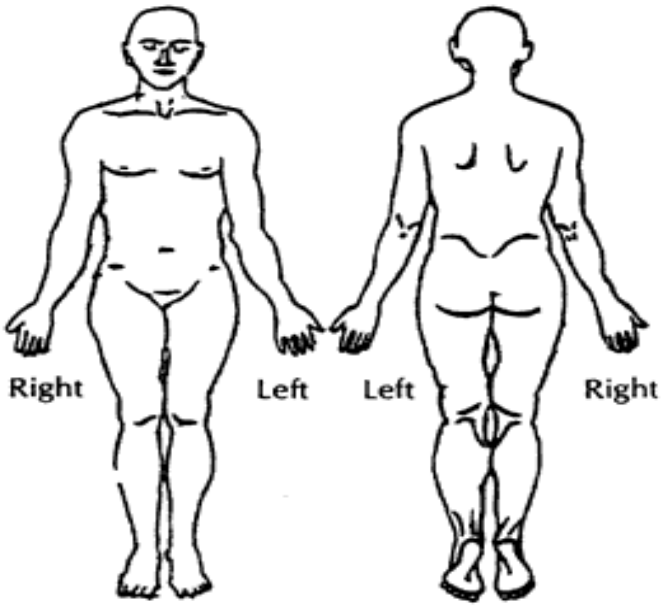
Other doctors seen for this condition:

Date	Name	Tests/Treatments	Results

PAIN DIAGRAM

Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness



Please list all SURGERIES, ACCIDENTS & FALLS, FRACTURES & DISLOCATIONS

Type_____ When_____ Type_____ When_____

Type_____ When_____ Type_____ When_____

Please list any medications and/or vitamins you take

What_____dosage:_____ What_____dosage:_____

What_____dosage:_____ What_____dosage:_____

Health Habits: How much per day or week?

Exercise: 1) Type_____ Frequency_____ 2) Type_____ Frequency_____

Sleep: Hours per night_____ ○ Good ○ Fair ○ Poor / ○ Back ○ Side ○ Stomach

Personal History: Have you ever had

○ High blood pressure ○ Cholesterol ○ Diabetes ○ Heart disease ○ Stroke ○ Asthma ○ Dizziness ○ Thyroid

○ Kidney disease ○ Indigestion ○ Abdominal pain ○ Cancer ○ Arthritis ○ Weight gain ○ Other_____

Family History: Has anyone in your family ever had

○ High blood pressure ○ Cholesterol ○ Diabetes ○ Heart disease ○ Stroke ○ Asthma ○ Dizziness ○ Thyroid

○ Kidney disease ○ Indigestion ○ Abdominal pain ○ Cancer ○ Arthritis ○ Weight gain ○ Other_____

Occupational Information: Job involves:

○ Sitting ○ Standing How long_____/_____ ○ Lifting How much weight_____

Do any of your work activities aggravate your present main complaints?

Please describe_____

_____

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date_____