Physicians Plus Spine and Rehab Center
Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

HOW DID YOU HEAR ABOUT US?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know ALL the ways you heard about our office.Put a check next to each source and then CIRCLE the main reason you selected this office.

Thank you!

Patient Name:_____

___ Physician referral (Please list name below)

___ Internet

___ Family Member/Sibling

___ Office Incentive (contest/free consultation flyer)

___ Insurance company

___ Direct mailings

___ Newspaper

___ Other:_____

Please list the names of whom referred you to us (if applicable so we may thank them properly):

_____

_____

_____

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Patient Data

Name _____ Date _____ Email _____

Patient Information

Address _____ City _____ State _____ Zip _____
Telephone (best number to reach you by) _____
Family Dr._____
Age _____ Birth date _____ Social Security # _____
Occupation _____ Employer_____
Marital Status _____ Spouse's name _____
Emergency contact _____ Phone _____

Insurance Information

Do you have health insurance? ❑ No ❑ Yes
Primary Insurance company _____
Phone _____ ID#_____ Group #_____
Secondary Insurance company (if any)_____
Phone_____ ID#_____ Group #_____

Current Complaints

Please describe the condition which brought you here_____
_____
_____

When did your symptoms first appear?_____

Do you what caused your condition? ❑ Yes ❑ No If yes, please describe.

_____

_____

Is the condition getting progressively worse? ❑ Yes ❑ No ❑ Unsure

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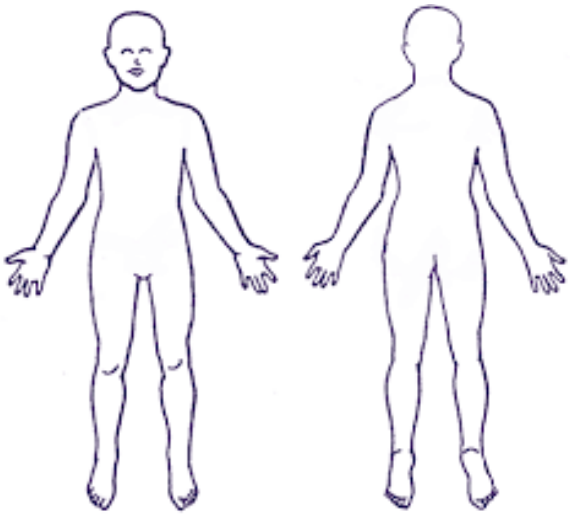
Current Complaints continued

Please use the diagram to draw the areas of you pain: (place an [x] on the areas)



How would you rate the severity of you pain from 0-10; 0 (being no pain at all) 10 (worst pain imaginable) _____

How would you describe your pain? (check all that apply)

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Other _____

☐ Burning ☐ Tingling ☐ Cramping ☐ Stabbing _____

Is your pain constant or does it come and go? _____

Does your pain interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Which activities or movements make you condition worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Twisting ☐ Turning

☐ Bending ☐ Pushing ☐ Pulling ☐ Other_____

Please describe any treatment which you have had for your present condition (if any). _____

_____

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Medical History

PCP _____ Date of last physical exam _____

Present medications:

Medication	Condition	Dose/Frequency

Additional medications: _____

Are you allergic to any medications? ☐ Yes ☐ No; if yes, what? _____

Medical conditions for which you are being treated for:

Condition	Doctor	Date of Initial Treatment

Have you had any significant trauma/injuries ☐ Yes ☐ No

If yes, please list and describe: _____

_____

_____

_____

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General Health Questionnaire

(1 being the worst and 10 being the best)

How would you rate your overall energy level? (1-10) _____

How would you rate your quality of sleep? (1-10) _____

Do you generally feel better in the ☐ Morning ☐ Evening ☐ No Difference

Do you crave certain types of foods? ☐ Sugar ☐ Salt ☐ Other _____

How would you rate the overall quality of your diet? (1-10) _____

Have you ever been addicted to ☐ Alcohol ☐ Opiates ☐ Heroin/Cocaine

Habits:

Alcohol ☐ Yes ☐ No _____ Drinks per (circle one) day/week/month

Tobacco ☐ Yes ☐ No _____ Cigarettes per day

Coffee ☐ Yes ☐ No _____ Cups per day

Soft drinks ☐ Yes ☐ No _____ Ounces per day

Do you use artificial sweeteners regularly ☐ Yes ☐ No

Do you Exercise ☐ Yes ☐ No _____ times per week. If yes please describe _____

_____

_____

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Patient request for Patient Records

Date: _____/_____/_____

Attention: _____

Patient Name: _____

I hereby authorize the release of my X-Rays/Medical Records and request that they be transferred to:

Physicians Plus Spine and Rehab Center

1106 Pulaski Hwy.

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Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care many be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at a Health Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature:_____

Date:_____

Physicians Plus Spine and Rehab Center

PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus Spine and Rehab Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed Name of Patient

_____

Signature of Patient/Authorized Representative of Patient

_____

Witness

Date: _____

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Medical Information Release Form
(HIPAA Release Form)

Name: _____
Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date:____/____/_____

Witness:_____ Date: ___/____/_____

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