CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date:_____

Patient Name:_____ Birth Date:_____ Age:_____

Address:_____ Sex: Male / Female (Circle one)

City:_____ State:_____ Zip:_____ Driver's License#:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Referred to this office by:_____ E-mail Address:_____

Employer:_____ Occupation/Type of Work:_____

Marital Status:_____ Spouse's Name:_____

Names & Ages of Children:_____

Are we billing: ___You ___Insurance ___Work Comp ___Auto Ins Name of Insurance:_____

Insured Person's Name:_____ Insured's Person's Date of Birth:_____

Primary Care Physician:_____ Date of Last Visit:_____

Emergency Contact Person:_____ Phone Number:_____

Current Health History

Give a brief description of your complaint:_____

_____

_____

_____

_____

When did this complaint start?_____

_____

Have you ever had this problem before?_____

_____

Is this complaint related to: ___ Car Accident ___ Work Accident

___ Other Accident ___ No Accident or Injury

If Accident:

Date of Accident:_____ Time of Accident:_____

Have you reported the accident?_____

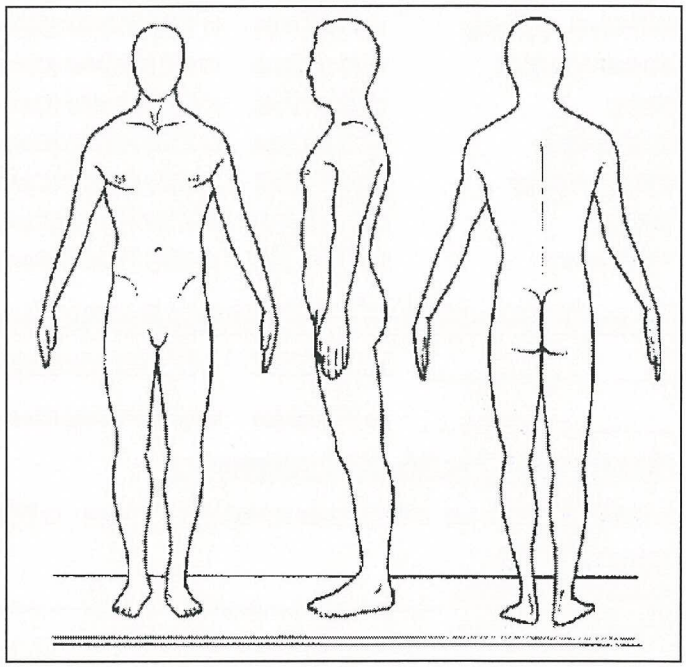
Rate your pain at **REST** from **0 (no pain) to 10 (worse pain ever had)**
Circle One

0--------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Rate your pain with **ACTIVITY** from **0(no pain) to 10 (worse pain)**
Circle One

0--------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Please mark areas of complaint on diagrams below:



Have you seen anyone else for this problem? _____ If yes, who? _____

Type of Treatment: _____ Results: _____

Have you had any X-rays, MRI's or CT Scans for this or any other spine or head condition? _____ If yes, where?_____

_____