CONFIDENTIAL PATIENT INFORMATION

Dear Patient: *Please complete this questionnaire. Your answers will help us determine if we can help you. If we sincerely believe we can help your condition satisfactorily, we will accept you as a patient. THANK YOU.*

Date: _____

Full Name: _____ S.S.#: _____ - _____ - _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status: _____

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

Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: (___) _____

Contact in case of emergency: _____ Phone: _____

WORK RELATED INJURIES

1. Are your symptoms the result of a work related injury? YES / NO
2. Date of the Accident _____ Type of Accident: _____
3. How long have you had these symptoms? _____
4. Are your symptoms getting worse? YES / NO CONSTANT / COMES & GOES
5. Have you ever had these symptoms before? YES / NO If yes, when? _____
6. Did you have immediate pain following the accident? YES / NO
7. Did you go to the hospital or medical center? YES / NO By ambulance? YES / NO
8. Which hospital / medical center did you go? _____ When? _____
9. What were your symptoms at that time? _____
10. Were x-rays performed? YES / NO If yes, what part of the body? _____
11. What other tests were performed? _____
12. What medications are you currently taking? _____
13. What makes the pain feel better? _____ Worst? _____
14. Do you have any medical conditions? _____
    (Diabetes, High Blood Pressure, Cancer, etc.)
15. Do you smoke? YES / NO If yes, how much? _____
16. Do you drink? YES / NO If yes, how much? _____

17. Please describe the accident: _____

_____

_____

18. Do you have an Attorney? If yes, what is his/her name? _____
19. What is the name of the Worker's Compensation insurance? _____
20. Do you have a claim number? _____
21. Did you fill out an accident report at work? _____
22. Do you have health insurance? If yes, which? _____ Please give your card to the front desk.
23. Have you seen anyone else for this condition? If yes, who? _____
24. Please circle your symptoms:

1. Headaches	6. Mid-back pain	Other: _____
2. Neck pain	7. Lower back pain	
3. Shoulder pain	8. Leg pain	
4. Arm pain	9. Ankle pain	
5. Vertigo	10. Chest pain	

25. On a pain scale of 1 – 10, 1 being almost no pain and 10 being the greatest, what do you rate your pain today? _____

To the best of my knowledge, the above information is accurate and describes my current condition.

Please Sign here: _____ Date: _____