Medical History/ Evaluation

Name:________________ Account #:____________ Date:____________

Ins. Type:________________

General Benefits:________________

Patient Responsibility: Copay:________ Per:________ Deductible:________ % Responsible:________________

Referring Physician:________________ Family Physician:________________

Date of Injury/Onset:________________ Date of first Doctor Visit for this injury:________________

Current Work Status:________________ Last date worked due to this injury:________________

Level of Recreation:________________ Home/Travel concerns:________________

Is an Attorney involved in this case? YES NO

Have you had any other Diagnostic or Rehabilitative Services for this injury/episode? YES NO

If so, what type? (i.e., X-Rays, MRI, EMG, other)________________ When?________________

Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4 ___

Type of Surgery:________________ Date(s) of Surgery(ies)________________

Are you currently taking any prescription or non-prescription medications? YES NO

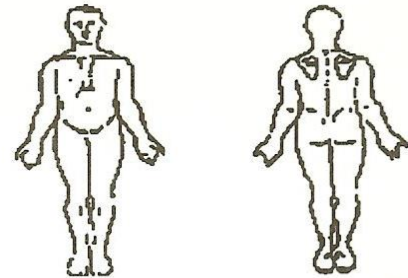
Anti-Inflamatories ________________ List Other Medications:________________

Muscle Relaxers ________________ ________________

Pain Medication ________________ ________________

How has pain changed since onset?________________

Indicate on Diagram where the pain is:



Do you now have or have you ever had any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	____	____
Shortness of Breath/Chest Pain	____	____
Coronary Heart Disease or Angina	____	____
Do you have a Pacemaker	____	____
High Blood Pressure	____	____
Heart Attack/Surgery	____	____
Stroke/TIA	____	____
Blood Clot/Emboli	____	____
Epilepsy/Seizures	____	____
Thyroid Trouble/Goiter	____	____
Anemia	____	____
Infectious Disease	____	____
Diabetes	____	____
Cancer or Chemotherapy/Radiation	____	____
Arthritis/Swollen Joints	____	____
Osteoporosis	____	____
Gout	____	____
Sleeping Problems/Difficulties	____	____
Emotional/Psychological problems	____	____
Bowel or Bladder Problems	____	____
Do You Smoke?________ How much?________________		
Severe or Frequent Headaches	____	____
Vision or Hearing Difficulties	____	____
Numbness or Tingling	____	____
Dizziness or Faintness	____	____

	YES	NO
Weakness	____	____
If so, where: ________________		
Weight Loss/Energy Loss	____	____
If so, where: ________________		
Hernia	____	____
Varicose Veins	____	____
Allergies	____	____
Any Pins or Metal Implants	____	____
Joint Replacement	____	____
Neck Injury/Surgery	____	____
Shoulder Injury/Surgery	____	____
Elbow Injury/Surgery	____	____
Back Injury/Surgery	____	____
Knee Injury/Surgery	____	____
Leg/Ankle/Foot Injury/Surgery	____	____
Are you Pregnant?	____	____
Alcohol Consumption? ______ How much?________________		

List any other information that would assist us in your care:________________

Would you like to speak with a social worker or vocational counselor about these aspects of your rehabilitation program?

Are you aware of your Diagnosis? YES NO Are you aware of your Prognosis? YES NO

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to________________regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature:________________ Date:________________

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature:________________ Date:________________

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