Health & Stability Spinal Care

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www.healthandstability.com

Confidential Patient Application

PATIENT INFORMATION:

Name: _____ Date: _____

What Do You Prefer To Be Called: _____
Sex: M or F
Date of Birth:_____
Age:_____
Home Phone: ( ) ____ - _____
Cell Phone: ( ) ____ - _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

Employer/Occupation: _____
Work Phone: ( ) ____ - _____ Retired? Yes No

SPOUSE INFORMATION:

Name: _____ Date of Birth: _____
Employer or
Retired? _____ Cell Phone: _____ - _____ - _____

How did you hear about us? _____

PRIMARY REASON FOR CONSULTING OUR OFFICE:

List your health concerns in order of importance:

Health Concern	What have you tried to solve this concern?	How long has this problem persisted?
1.		
2.		
3.		
4.		
5.		

Circle all that apply (past or present):

Foot Pain
Hand Pain
Low Back Pain
Neck Pain
Foot Numbness
Hand Numbness
Diabetes
High Cholesterol
High Blood Pressure
Pacemaker-Defib
Herniated Disc
Bulging Disc
Spinal Stenosis
Degenerative Disc
Vascular Problems
Leg Pain
Plantar Fasciitis
Morton's Neuroma
Cancer
Chemotherapy
Arthritis in Hands
Arthritis in Feet
Implanted Cord/ Bladder Stimulator
Sciatica
Pinched Nerve
Poor Circulation
Joint Replacement
Foot Surgery
Poor Wound Healing
Excessive Thirst or Urination

Is there a certain time of day these problems are better or worse?

_____
_____
_____
_____

List the things you have used for these problems:

Gabapentin Neurotin Lyrica Cymbalta Physical Therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams Statins

Is your balance/ walking ability affected? If yes, please, describe:

_____
_____
_____
_____

What do you think is causing your problem?

_____
_____
_____
_____

Name all doctors you have seen for these problems and which treatment you have received:

_____
_____

Symptom Description

Have your symptoms: Improved Worsened Stayed the Same

List anything that makes your condition worse:_____
_____

List anything that makes your condition better:_____
_____

How would you describe the symptoms? *Please, Circle all that apply:*

Aching Pain
Stabbing Pain
Sharp Pain
Tiredness
Numbness
Tingling
Pins & Needles
Pain
Heavy Feeling
Hot Sensation
Throbbing Pain
Dead Feeling
Cold Hands/ Feet
Cramping
Swelling
Burning
Electric Shocks

Is the condition interfering with any of the following:

Sleep
Recreational Activities
Work
Walking
Daily Activities
Standing

Social History

Do you Smoke? YES NO If yes, how many cigarettes daily?_____
Do you Drink? YES NO If yes, how many drinks weekly? _____
Do you Exercise regularly? YES NO If yes, please, describe the type & how often:
_____
_____

Current Pain Levels

How would you rate your pain in the last week?
NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?
NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Release of Information to Doctor

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name:_____ Signature:_____

Please, give name, address, and office phone number of your primary care physician.
Name:_____ Phone:_____

When were you last seen in their office? _____

Please Provide Your Doctors Clinic Name/Address Here:

_____
_____

May we update your Medical Doctor with our Findings on your Condition? YES NO

Current Medications, Supplements, and Allergies

List all Allergies to Medication, Food, or other items here:

1. _____
2. _____
3. _____
4. _____

List all Prescription Medications currently taking: (if more than four please provide list)

Name:	Times Taken Daily:
1.	
2.	
3.	
4.	

List all Nutritional Supplements (vitamins, herbs, homeopathies, etc.)

Name:		Times Taken Daily:
1.		
2.		
3.		
4.		

Is your condition made worse with physical stress (standing, sitting, driving)? YES NO

Is your condition made worse by mental stress? YES NO

Do you have insurance? YES NO

Do you have Medicare? YES NO

Do you have Disability insurance? YES NO

Release of Information for Insurance

I authorize Health and Stability Spinal Care to release any information or office records necessary to process insurance claims.

Patient Signature_____ Date_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at time of service, whether or not my insurance company will reimburse me. I hereby authorize the doctors at Health and Stability Spinal Care to administer care as they so deem necessary. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

_____ _____

Patient's (Parent or Guardian's) Signature Date

If you have insurance please provide your ID Card when you return this form to the receptionist. We will gladly provide you with the form you need to submit to your insurance company for reimbursement. Medicare does not reimburse for services in our office, therefore, we do not provide forms for submission.

We look forward to serving you!

Patient Quality of Life Survey

Name:_____ **Date:**_____

Please take several minutes to answer these questions so we can help you get better. (Please, circle as many as apply)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition / Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): _____

2. How did the previous method(s) work out for you?

a. Bad Results
b. Some Results
c. Great Results
d. Nothing Changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this condition might be affecting, or beginning to affect?

a. Job
b. Kids
c. Future Ability
d. Marriage
e. Self- Esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family Health Problems
b. Heart Disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need Surgery

6. How has your health condition affected your job, relationships, finances, family, or other activities? *Please give examples*:

_____
_____
_____
_____

7. What has that cost you? *(time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:*

_____
_____
_____
_____

8. What are you most concerned with regarding your problem?

_____
_____

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? *Please, be specific:*

_____
_____
_____
_____

10. What would be different or better without this problem? *Please, be specific:*

_____
_____

11. What do you desire most to get from working with us?

_____
_____

12. What would that mean to you?

_____
_____