

Confidential Medical History/Evaluation



Account #: _____

Name: _____ Date: ____/____/____ Referring MD: _____

Address: _____ Date of Birth: _____ Phone: _____ SS#: _____

Insurance Company: _____ Subscriber ID: _____ Group #: _____

Insured Employer/Address: _____ Phone: _____

Occupation: _____ Is this injury: Work Related Auto Accident

Chief Complaint: _____ Date of Injury: ____/____/____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other: _____

Do you have any of the following?	YES	NO	Pain when performing the following activities?	MILD	SEVERE	UNABLE
Asthma, Bronchitis or Emphysema	___	___	Bending	___	___	___
Shortness of Breath/Chest Pain	___	___	Care-Infirm Family	___	___	___
Coronary Heart Disease	___	___	Carrying Groceries	___	___	___
Do you have a Pacemaker	___	___	Change Position-Sit-Stand	___	___	___
High Blood Pressure	___	___	Climb Stairs	___	___	___
Heart Attack/Surgery	___	___	Driving	___	___	___
Stroke/TIA	___	___	Extended Computer Use	___	___	___
Blood Clot/Emboli	___	___	Feeding	___	___	___
Epilepsy/Seizures	___	___	Household Chores	___	___	___
Thyroid Trouble/Goiter	___	___	Kneeling	___	___	___
Anemia	___	___	Lift Children	___	___	___
Infectious Disease	___	___	Lifting	___	___	___
Diabetes	___	___	Pet Care	___	___	___
Cancer or Chemo/Radiation	___	___	Reading (Concentration)	___	___	___
Arthritis/Swollen Joints	___	___	Self Care-Bathing	___	___	___
Osteoporosis	___	___	Self Care-Dressing	___	___	___
Varicose Veins	___	___	Self Care-Shaving	___	___	___
Gout	___	___	Sexual Activities	___	___	___
Sleeping Difficulties	___	___	Sleep	___	___	___
Emotional/Psychological Problems	___	___	Static Sitting	___	___	___
Bowel or Bladder Problems	___	___	Static Standing	___	___	___
Severe/Frequent Headaches	___	___	Walking	___	___	___
Vision/Hearing Difficulties	___	___	Yard Work	___	___	___
Dizziness or Faintness	___	___	Sports _____			
Are you pregnant?	___	___	Recreational Activities _____			
Do you smoke?	___	___	How many daily/weekly? _____			
Alcohol Consumption?	___	___	How much daily/weekly? _____			
Other Medical Conditions _____						

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: _____