eugene SPINAL CARE

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GENERAL INFORMATION

Name _____
(Last) *(First)* *(Middle I)*

Preferred Name _____

Date of Birth _____ Age: _____

Gender ☐ Male ☐ Female Height: _____ Weight: _____

Guardian (if under 18) _____ Marital Status _____

Address _____
Street *Apt No.*

_____
City *State* *Zip*

Home Phone _____

Cell Phone _____

Work Phone _____

Fax _____

Email _____

Employer _____

Occupation _____ If retired, previous occupation: _____

Emergency Contact _____
Name *Phone*

_____
Relationship to patient

Primary Care Physician _____

Referred by _____

INSURANCE INFORMATION

Person responsible for account _____
Name *Address* *Phone*

Primary Insurance _____

Secondary Insurance _____

CURRENT COMPLAINTS

Primary complaint—please describe:_____

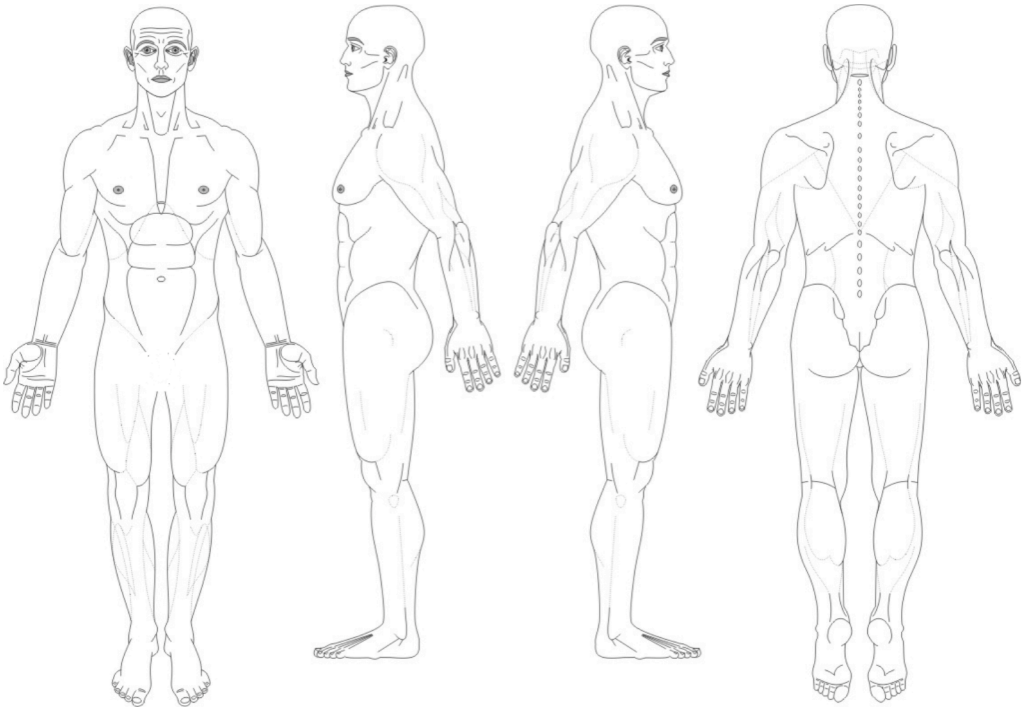
_____

Secondary complaint (if applicable)—please describe:_____

_____

Tertiary complaint (if applicable)—please describe:_____

_____



Please indicate on diagram, with X or shading, areas of symptoms, including pain, numbness, burning, tingling or other problem.

Regarding your **primary complaint:**

How long have you had this complaint?_____

What seemed to be the initial cause? _____

Check all that apply regarding quality of discomfort:

☐sharp pain ☐dull pain ☐shooting pain ☐ache ☐soreness ☐weakness
☐throbbing/gnawing ☐numbness ☐gripping/constricting ☐burning ☐tingling

What is the severity of discomfort?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

How often is discomfort present? ☐constant(76-100% of time) ☐frequent (51-75%)
☐occasional (26-50%) ☐intermittent (25% or less)

Since it began, the problem has been: ☐increasing ☐decreasing ☐not changing

What treatment have you received for this present condition?_____

_____

Were you previously treated for a different occurrence of this same condition? Yes / No

If yes, by whom?_____

What makes your problem **better**? (check all that apply) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

What makes your problem **worse**? (circle) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

Do your symptoms affect your sleep? Yes / No

Are your symptoms affecting your ability to work or care for self?

☐no effect ☐some physical restrictions ☐need limited assistance with everyday tasks
☐need assistance often ☐significant inability to function without assistance ☐am totally disabled

Regarding your **secondary complaint** (if applicable)**:**

How long have you had this complaint?_____

What seemed to be the initial cause? _____

Check all that apply regarding quality of discomfort:

☐sharp pain ☐dull pain ☐shooting pain ☐ache ☐soreness ☐weakness
☐throbbing/gnawing ☐numbness ☐gripping/constricting ☐burning ☐tingling

What is the severity of discomfort?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

How often is discomfort present? ☐constant(76-100% of time) ☐frequent (51-75%)
☐occasional (26-50%) ☐intermittent (25% or less)

Since it began, the problem has been: ☐increasing ☐decreasing ☐not changing

What treatment have you received for this present condition?_____

_____

Were you previously treated for a different occurrence of this same condition? Yes / No

If yes, by whom?_____

What makes your problem **better**? (check all that apply) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

What makes your problem **worse**? (circle) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

Do your symptoms affect your sleep? Yes / No

Are your symptoms affecting your ability to work or care for self?

☐no effect ☐some physical restrictions ☐need limited assistance with everyday tasks
☐need assistance often ☐significant inability to function without assistance ☐am totally disabled

Regarding your **tertiary complaint** (if applicable)**:**

How long have you had this complaint?_____

What seemed to be the initial cause? _____

Check all that apply regarding quality of discomfort:

☐sharp pain ☐dull pain ☐shooting pain ☐ache ☐soreness ☐weakness
☐throbbing/gnawing ☐numbness ☐gripping/constricting ☐burning ☐tingling

What is the severity of discomfort?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

How often is discomfort present? ☐constant(76-100% of time) ☐frequent (51-75%)
☐occasional (26-50%) ☐intermittent (25% or less)

Since it began, the problem has been: ☐increasing ☐decreasing ☐not changing

What treatment have you received for this present condition?_____

_____

Were you previously treated for a different occurrence of this same condition? Yes / No

If yes, by whom?_____

What makes your problem **better**? (check all that apply) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

What makes your problem **worse**? (circle) ☐nothing ☐lying down ☐walking
☐standing ☐sitting ☐movement/exercise ☐inactivity ☐other _____

Do your symptoms affect your sleep? Yes / No

Are your symptoms affecting your ability to work or care for self?

☐no effect ☐some physical restrictions ☐need limited assistance with everyday tasks
☐need assistance often ☐significant inability to function without assistance ☐am totally disabled

HEALTH HISTORY

Please list all hospitalizations, surgeries, auto accidents, traumas, falls and major illnesses by age at time of occurrence:

Birth to age 6 _____

Age 7-12 _____

Age 13-20 _____

Age 21-40 _____

Age 41-60 _____

Age 61+ _____

Please list all current prescription medications, supplements, and over the counter medications:

_____

_____

_____

_____

_____

_____

_____

_____

General physical activity	☐ no regular exercise program ☐ light exercise program ☐ strenuous exercise program	
Physical activity at work	☐ sitting >50% ☐ light manual labor	☐ manual labor ☐ heavy manual labor
Stress level	☐ no stress ☐ minimal stress	☐ moderate stress ☐ greatly stressed
Do you wear:	☐ heel lifts ☐ sole lifts ☐ insoles	☐ arch supports ☐ negative heels ☐ platform shoes

FAMILY HEALTH INFORMATION

Information about your immediate family members, (brothers, sisters, parents, grandparents), will give us a better understanding of your total health picture.

Relationship	Present and past health problems

HEALTH HISTORY (continued)

Please check all boxes that apply for past and present symptoms.

Past	Present			Past	Present	
☐	☐	Neck pain		☐	☐	Irregular menstrual flow
☐	☐	Shoulder pain		☐	☐	Profuse menstrual flow
☐	☐	Pain in upper arm or elbow		☐	☐	Breast soreness/ lumps
☐	☐	Hand pain		☐	☐	Vaginal discharge
☐	☐	Upper back pain		☐	☐	PMS
☐	☐	Pain in upper leg or hip		☐	☐	Loss of bladder control
☐	☐	Pain in low back		☐	☐	Painful urination
☐	☐	Pain in lower leg or knee		☐	☐	Frequent urination
☐	☐	Pain in ankle or foot		☐	☐	Abdominal pain
☐	☐	Jaw pain		☐	☐	Constipation/irregular bowel habits
☐	☐	Swelling/stiffness of joints		☐	☐	Difficulty swallowing
☐	☐	Fainting, visual disturbances, nausea		☐	☐	Heartburn/indigestion
☐	☐	Convulsions		☐	☐	Dermatitis/eczema/rash
☐	☐	Dizziness		☐	☐	
☐	☐	Headaches		Please check any of the following that apply to you:		
☐	☐	Muscular incoordination			☐	Tobacco use
☐	☐	Tinnitus (ringing in ears)			☐	Alcohol use
☐	☐	Rapid heart beat			☐	Drug or alcohol dependence
☐	☐	Chest pain			☐	Coffee/tea/caffeinated beverages:__cups/day
☐	☐	Abnormal weight	☐gain			
☐	☐		☐loss	Yes	No	
☐	☐	Excessive thirst		☐	☐	Do you have a permanent disability rating?
☐	☐	Chronic cough				Location:_____
☐	☐	Chronic sinusitis				Date rating received___/___/____
☐	☐	General fatigue				Rating percentage____%

Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition	Past	Present	Condition
☐	☐	Depression	☐	☐	Emphysema
☐	☐	Aortic Aneurysm	☐	☐	Arthritis
☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Angina	☐	☐	Ulcer
☐	☐	Heart attack	☐	☐	Kidney stones
☐	☐	Stroke	☐	☐	Bladder infection
☐	☐	Asthma	☐	☐	Kidney disorders
☐	☐	Cancer	☐	☐	Colitis
☐	☐	Prostate problems	☐	☐	Irritable colon
☐	☐	Anorexia	☐	☐	HIV/AIDS
☐	☐	Blood disorder	☐	☐	Other_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process any insurance claim. I also request payment of government benefits either to myself or to the party who accepts this assignment.

Signed_____ Date_____