

PATIENT HISTORY – please fill out completely

Date of Birth _____ Age _____ Social Security # _____
Last _____ First _____ Nickname/Preferred Name _____
Address _____
City _____ ST _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
Email _____ May we send you our online newsletter? yes no
Your Occupation _____ Employer _____ Spouse's Name _____
Primary Physician _____ Who may we thank for referring you to this office? _____
Emergency Contact: _____ Phone Number: _____

PRIMARY COMPLAINT: _____
Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
What makes the symptoms increase? _____ What relieves the symptoms? _____
Type of Pain: *circle all that apply* Shooting Burning Radiating Aching Cramping Tingling Numbness Throbbing Spasm Stiffness
How often do you experience these symptoms? Occasionally Frequently Constantly
Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
Please list all previous treatments for this condition (give doctor's name and dates if possible) _____
Do you have any family members who suffer from the same complaint? _____

SECONDARY COMPLAINT: _____
Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
What makes the symptoms increase? _____ What relieves the symptoms? _____
Type of Pain: *circle all that apply* Shooting Burning Radiating Aching Cramping Tingling Numbness Throbbing Spasm Stiffness
How often do you experience these symptoms? Occasionally Frequently Constantly
Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
Please list all previous treatments for this condition (give doctor's name and dates if possible) _____
Do you have any family members who suffer from the same complaint? _____

Do you smoke? yes no If yes, how many packs per week? _____
Have you ever smoked in the past? yes no If yes, when did you quit? _____
Do you take birth control? yes no Have you ever taken birth control in the past? yes no
Do you consume alcohol? yes no If yes, how many drinks per week? _____
Do you consume caffeine? yes no If yes, how many drinks per day? _____
Do you exercise? yes no If yes, how many times per week and what type? _____
Do you have a high stress level? yes no If yes, list reasons: _____

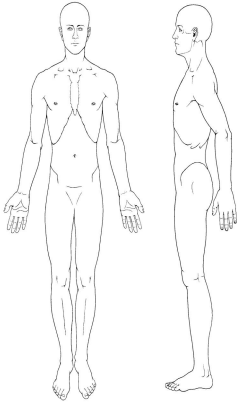
Please list any medications or vitamins you are currently taking:

-over-

PATIENT SIGNATURE _____

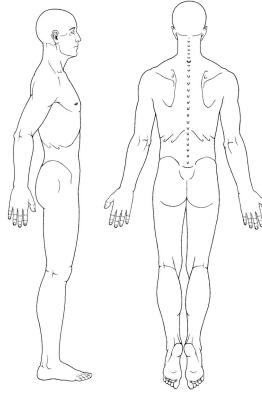
DATE _____

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Please mark off the areas of your complaint on the diagrams with the following indicators:

- PPP = pain
- NNN = numbness
- TTT = tingling
- BBB = burning
- CCC = cramping
- XXX = other



Please list all surgeries, injuries, accidents, falls, etc:

Please circle if you have had any of the following:

- | | | | | |
|--------------------------|----------------------------|----------------------------|-----------------------------|---------------------------|
| AIDS/HIV | Chemical Dependency | Hepatitis | Osteoporosis | Suicide Attempt |
| Alcoholism | Chicken Pox | Hernia | Pacemaker | Thyroid Problem |
| Allergy Shots | Diabetes | Herpes | Parkinson's Disease | Tonsillitis |
| Anemia | Disc Degeneration | High Blood Pressure | Pinched Nerve | Vaginal Infections |
| Anorexia | Emphysema | High Cholesterol | Pneumonia | Venereal Disease |
| Arthritis | Epilepsy | Kidney Disease | Polio | Other (list): |
| Asthma | Glaucoma | Liver Disease | Prostate Problem | _____ |
| Bleeding Disorder | Goiter | Measles | Prosthesis | _____ |
| Breast Lump | Gonorrhea | Migraine | Psychiatric Care | _____ |
| Bronchitis | Whooping Cough | Mononucleosis | Rheumatic Fever | _____ |
| Bulimia | Heart Attack | MS | Rheumatoid Arthritis | _____ |
| Cancer | Gout | Miscarriage | Scarlet Fever | _____ |
| Cataracts | Heart Disease | Mumps | Stroke | _____ |

CONSENT TO TREAT: I hereby authorize the Main Street Health Center doctors and their assistants to perform examinations, physical therapy, and / or noninvasive diagnostic testing (including X-rays), and any other treatment that is medically necessary to me today and throughout the course of my treatment plan.

Signature: _____

Date: _____

CONSENT TO TREAT A MINOR CHILD: I, _____, hereby give my permission to Main Street Health Center to treat my minor child with examinations, physical therapy and any other noninvasive procedures that are medically necessary.

Parent /Guardian Signature: _____

Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read. I was also informed by Main Street Health Center that a copy of these privacy practices can be made available to me anytime.

Signature: _____

Date: _____

ASSIGNMENT & RELEASE I certify that I, or my dependent(s), have insurance coverage with above stated insurance company and assign directly to Main Street Health Center all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Witness

PATIENT SIGNATURE _____

DATE _____