Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Date of Birth _____ Age_____ Sex: M F Email_____

*Best contact number to reach you _____ Cell / Home / Work

Is it OK to text or email you appointment reminders? Yes / No

If yes, please indicate cell phone carrier (AT&T, Verizon, Sprint, other.)_____

Social Security # (for insurance purposes only) _____

Emergency Contact & Phone #_____Name of Spouse\Guardian (if minor)_____

Occupation_____

Your Primary Care Physician (PCP)_____Phone_____

How did you hear about us?_____
(Newspaper ad, Online, Existing Patient)

Do you have health insurance? Yes / No Is your injury related to an automobile or work related accident? Yes / No

List your chief complaints in order of severity:

1._____ When did it start? _____
(gradual/sudden)

2. _____ When did it start? _____ (gradual/sudden)

What is the severity of your problem?

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

Chronology/timing/prior episodes:

Have you had this condition before? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month?

Type of pain (please circle one): sharp, dull, aching, shooting Is your condition getting worse? Yes/No

What makes it feel better? _____

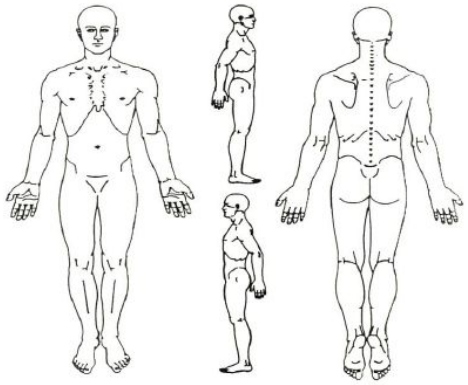
What make it feel worse?

_____

Does your pain travel? Yes / No If yes,
where_____

If Neck Pain – Does it shoot down your arms?	Yes	No
Any numbness or tingling in arms or hands	Yes	No
Any weakness in arms/hands	Yes	No
If Back Pain- Does it shoot down your legs/feet	Yes	No
Any numbness or tingling in legs or feet	Yes	No
Any weakness in legs/feet	Yes	No

Indicate Your Pain on the Diagram:



How are your symptoms affecting your lifestyle? (Eg. job, relationships, recreational activities, household chores)?

_____

Do you currently have, or have you had any of the following conditions or symptoms? Circle all that apply

Headaches	Wrist of hand pain	Stomach Problems	Depression
Knee Pain	Numbness/tingling	Ringing in ears	Anxiety
Neck Pain	Chest Pain	Loss of balance	Shoulder pain
Low back pain	Heart Conditions	Nervousness	Kidneys
Hip Pain	High blood pressure	Cancer	Bladder
Fatigue	Shortness of breath	HIV	Arthritis
Vertigo	Loss of smell/taste	Dizziness	Joint swelling
Jaw pain	TMJ	Insomnia	Stomach/GI

Diabetes (Insulin) Diabetes (No Insulin)
Other:_____

Treatment History/relevant prior injuries:

Have you seen anyone else about chief complaint? _____

If yes, what services were performed (circle all that apply) Chiropractic/Physical Therapy/Acupuncture/Pain Management

Provider Name_____Facility_____

Was the treatment(s) successful? _____

List your hospitalizations, operations and/or serious illnesses_____
_____

List all medications you are currently taking_____

List any allergies_____

Social habit use and how often:

Tobacco?

_____

Alcohol?

_____

Is there a family History of:

Father's side:	Heart Disease	Arthritis	Cancer	Diabetes	other
Mother's side:	Heart Disease	Arthritis	Cancer	Diabetes	other

_____

HIPAA Compliance Acknowledgement

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

This notice is in effect as of April 15, 2003.

PATIENT'S STATEMENT OF AUTHORIZATION AND ACKNOWLEDGEMENT

Monmouth Pain and Rehabilitation:

a) Is required by federal law to maintain the privacy of your protected health information (PHI), and to provide you with a copy of this Privacy Notice detailing Monmouth Pain & Rehabilitation, P.C. legal duties and privacy practices with respect to your PHI.
b) May be required by State law to maintain greater restrictions on the use or release of your PHI than that which is provided under federal law. Monmouth Pain & Rehabilitation, P.C. is required to, and will comply with all required State statutes.
c) Is required to abide by the terms of this privacy notice.
d) Reserves the right to change the terms of this privacy notice to make the new privacy notice provisions effective for your entire PHI that it maintains.
e) Will distribute any revised Privacy Notice to you prior to implementation.
f) Will comply with our complaint policy, and will not retaliate against you for filing a complaint.
By subscribing my name below, I acknowledge that I have read and understood this Privacy Notice. Furthermore, I give Monmouth Pain & Rehabilitation, P.C. the expressed written consent to display my name in any "In-Office" usages, including but not limited to sign-in sheet, files, charts, mobile devices, and e-mail. I also understand that if my name is requested to be used for promotional purposes outside of the office, a separate acknowledgement of permission will made in writing.

ACCEPT TERMS: ____

PATIENT SIGNATURE DATE