MONMOUTH PAIN AND REHABILITATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Date-of-Birth _____ Age _____ Sex: M F Social Security _____

E-Mail: _____

*Best contact number to reach you _____ cell/home/work

Emergency Phone # _____ Name of spouse/Guardian (if minor) _____

Your Occupation_____

How did you hear about us? _____

(Newspaper, Online, Patient Referral – Please be as specific as possible)

Do you have insurance? **Yes/No** Is your accident associated with an automobile or work related accident? **Yes/No**

If yes, what was the date of the accident _____

Primary Care Physician: _____ Primary Care Phone Number: _____

List your chief complaints in order of severity:

1. _____ When did it start_____(gradual/sudden)
2. _____ When did it start_____(gradual/sudden)
3. _____ 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)

Height: _____ Weight: _____

Have you had treatment for this condition? If so, please indicate *where and when*_____

_____

Was the treatment(s) successful? **Yes/No** If no why _____
Have you ever had surgery including this current condition? **If yes please list the type of surgery and the year it was done**:

_____

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

What type of pain? (Please circle one) ***Sharp*** ***Dull*** ***Aching*** ***Shooting*** is your condition getting worse? **Yes/No**

What makes it feel better? _____

What makes it feel worse? _____

Please list your activities of daily living which you've had difficulty doing (Eg. Job, relationship, recreational activities, household chores) _____

Does your pain travel? **Yes/No** If yes, please indicate where _____

Neck

Do you have any numbness or tingling in the arms and/or hands? **Yes/No** If yes, for how long? _____

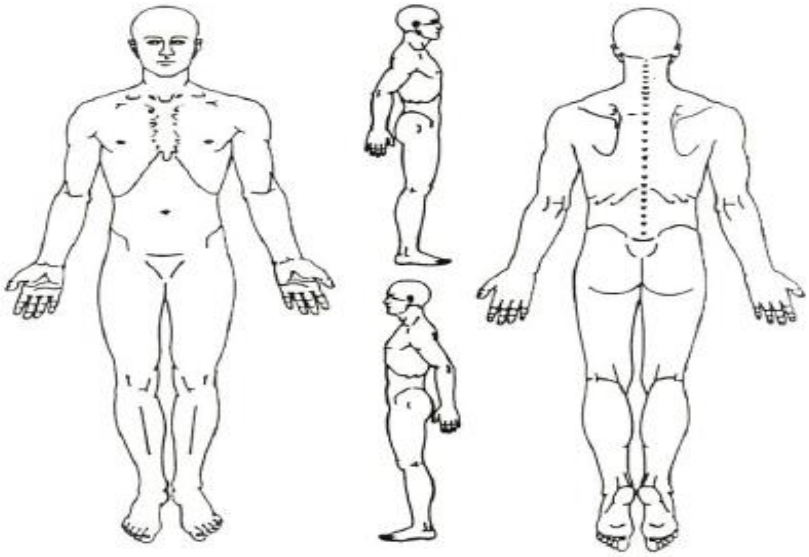
Do you have any weakness in the arms and/or hands? **Yes/No** If yes, for how long? _____

Back

Do you have any numbness or tingling in the legs and or feet? **Yes/No** If yes, for how long? _____

Do you have any weakness in the legs and/or feet? **Yes/No** If yes, for how long? _____

Indicate Your Pain on the Diagram:



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

Headaches	*Vertigo/Dizzy spells*	*Jaw pain*	*Circulation Problems*
Cardiac conditions	*High blood pressure*	*Heart Attack*	*Pace Maker*
TMJ	*Ringing in ears*	*Loss of balance*	*Osteoporosis*
Arthritis	*Nervous Disorders*	*HIV*	*Dizziness*
Claustrophobia	*Muscle spasms*	*Depression*	*Anxiety*
Kidneys Problems	*Cancer*	*Rheumatoid Arthritis*	*Joint swelling*
Stomach/GI	*Diabetes Type I*	*Diabetes Type II*	*Stroke*
Speech Problems	*Sexual Difficulty*	*Sinus/Allergy problems*	*Thyroid*
Sensitivity to Heat	*Sensitivity to Cold*	*Metal Implants*	*Immune system disorder*
Non-healing sores	*Seizures*	*Metal illness*	*Are you pregnant?*

List your hospitalizations, operations and/or serious illnesses

_____

_____

List all medications prescribe and over-the-counter you are currently taking_____

_____

_____

_____

List any allergies_____

Social habit:

Tobacco? _____How often_____

Alcohol? _____How often_____

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