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 Contact Name: ____________________ Emergency Contact Phone Number:_______________

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 pain associated with an automobile or work related accident? **Yes/No**

If yes, what was the date of the accident ____________________________________

Do you have a Primary Care Physician? Yes No If yes, please fill out the information below:

Primary Care Physician: ___________________________ Primary Care Town: ________________

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? _________________________

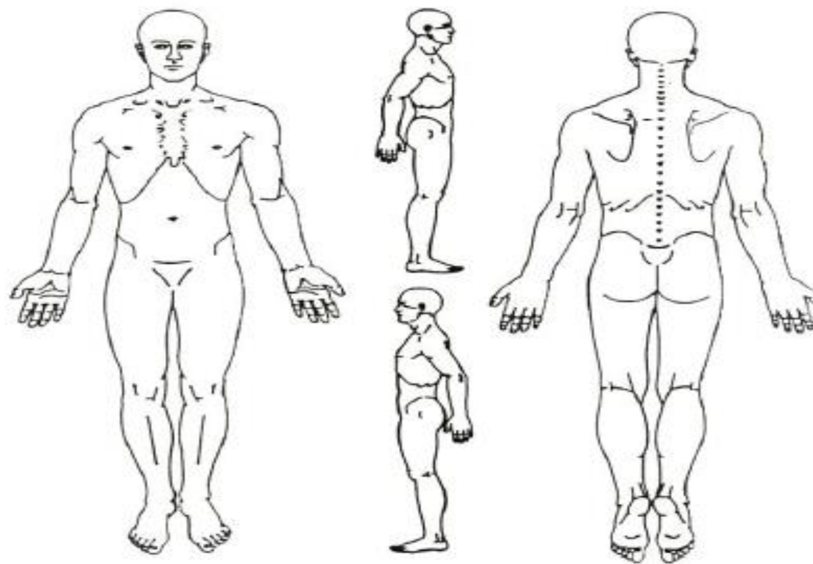
Do you have any weakness in the arms and/or hands? **Yes/No** If yes, for how long? ____________________________________

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*	*Mental illness*	*Are you pregnant?*

List your hospitalizations, operations and/or serious illnesses____

____

List all medications you are currently taking, prescribed and over-the-counter____
____

____

____

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 DAT