Massapequa Pain Management & Rehabilitation

CONFIDENTIALPATIENT INFORMATION

In order to serve you properly, we need the following information. Thank you.

Name ______________________________ Social Security # ____________________

Address ____________________ City ____________ State ______ Zip __________

Age ______ Birth date ______ Marital Status: M S W D # Children ______ Spouse's Name ______________

Home Phone ______________ Cell Phone ______________Cell Phone Carrier ______________

Occupation ______________________ Email ______________________

In case of emergency call ______________________ Phone ______________

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ Unknown

Race: □ American Indian/Alaskan □ Asian □ African American/Black □ Native Hawaiian □ Caucasian/White □ Other

Pri. Language: □ English □ Spanish □ Chinese □ Italian □ Japanese □ French □ Portuguese □ German □ Russian □ Other

Do you want your record electronically sent? □ Yes □ No Who may we thank for referring you? ______________

HEALTH INFORMATION

Present Complaint ______________________________

____

Pain Scale: no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
moderate pain

How long have you had this condition? ______________

Have you had similar conditions in the past? ______________

Does this condition affect your work? Yes □ No □

Does this condition affect your family or social life? Yes □ No □

What aggravates this condition? ______________

____

Other Doctors seen for this condition ______________

____

Are you taking any medication? ______________

____

Are you allergic to any medications? ______________

____

What helps your symptoms? ______________

____

Have you had any surgery, falls or accidents? Yes □ No □

When? __________ Please describe ______________

____

Primary Care Physician ______________

Date of last physical examination ______________

	Yes	No
Pregnant	□	□
Headaches	□	□
Neck Pain	□	□
Arm or Shoulder Pain	□	□
Back Pain	□	□
Hip or Leg Pain	□	□
Chest Pain	□	□
Abdominal Pain	□	□
Thyroid Problem	□	□
Heart Trouble	□	□
Angina	□	□
Circulatory, Phlebitis	□	□
High or Low Blood Pressure	□	□
Tuberculosis	□	□
Prostate Disorder	□	□
Kidney Problems	□	□
Rheumatic Fever	□	□
Lung or Bronchial Disorder	□	□
Digestive Disorder	□	□
Constipation	□	□
Bleeding Disorder	□	□
Diabetes	□	□
Swollen Joints	□	□
Asthma	□	□
Dizziness	□	□
Numbness	□	□
Ulcer	□	□
Depression	□	□
General Fatigue	□	□
Stroke	□	□
Seizure Disorder	□	□
Anemia	□	□
Glaucoma	□	□
Cancer	□	□
Recent Weight Loss	□	□
Any Other Health Illness	□	□

INSURANCE INFORMATION

Is this condition due to:

A work related injury? Yes □ No □ An auto accident? Yes □ No □

If you answer yes to either of the above questions, please complete other side of this form.

Are you covered by Medicare? # ______________

Do you have Major Medical Insurance? Yes □ No □

Company ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that I authorize payment directly to this office which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize the release of any medical or other information pertinent to my treatment and necessary to process any insurance claims.

Patient's Signature ______________________________ Date ______________

Guardian/Parent Permission to treat minor ______________________ Date ______________

Information taken by ______________________________ Date ______________

WORK RELATED INJURY INFORMATION:

Date of injury: ____________________ Time: _____________ Accident location: ________________

Description of accident ____

____

Workman's Compensation Case # ____

Insurance Company _______________________________________ Case # ____________________

Address ____

Employer's Name ____

Address: ____

Hospitalized? □ Yes □ No Name of Hospital: ______________________________________X-ray taken? □ Yes □ No

Other Doctors seen ____

Are you working now? □ Yes □ No Time lost from work (dates) _________________________to_______________________

Have you done any physical therapy? □ Yes □ No When? _______________________________________

Have you had previous chiro? □ Yes □ No When? ____

MOTOR VEHICLE AUTO ACCIDENT INFORMATION:

Date: __________________________ Time: __________________ Location: _________________________

How did the accident occur? □ Auto Collision □ Other ______________________________________

If not an auto collision, please describe the circumstances: ________________________________

____

If an auto accident, were you □ Driver □ Passenger □ Pedestrian

If an auto collision, were you struck from □ Behind □ Right Side □ Left Side □ Front □ Auto was Parked

Did your car strike the other(s) involved? □ Yes □ No

Or did the other car strike yours? □ Yes □ No □ Undetermined

As a result of the accident, were traffic citations issued to you? □ Yes □ No

To the driver of the other car? □ Yes □ No

List the extent of the injuries as you know them: ____

____

____

Did you require post-accident hospitalization? □ Yes □ No

Check Symptoms you noticed since the accident:

□ Headache	□ Dizziness	□ Light Sensitivity	□ Diarrhea
□ Neck pain	□ Head seems too heavy	□ Loss of memory	□ Feet cold
□ Neck stiff	□ Pins and needles in arms	□ Ears ring	□ Hands cold
□ Sleeping problems	□ Pins and needles in legs	□ Face Flushed	□ Stomach upset
□ Back pain	□ Numbness in fingers	□ Buzzing in ears	□ Constipation
□ Nervousness	□ Numbness in toes	□ Loss of balance	□ Cold sweats
□ Tension	□ Shortness of breath	□ Fainting	□ Fever
□ Irritability	□ Fatigue	□ Loss of smell	□ ________________
□ Chest pain	□ Depression	□ Loss of taste	□ ________________

Have you lost any days of work? □ Yes □ No Dates: _________________________to_______________________

Insurance Companies involved: ____

My Company: ____

Company of person responsible for injuries: ____

Have you been contacted by an insurance adjuster/company rep. regarding this claim? □ Yes □ No

Do you have an attorney that has advised you in this case? □ Yes □ No

Attorney's name: _____________________________________ Telephone: _________________________

Address: ____