

Pain Relief Center

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PATIENT INFORMATION FORM

| | | |
|------------------|-------------------|--------------|
| Office Use Only: | Chiro: _____ | Mass: _____ |
| New PT# _____ | Previous PT _____ | Update _____ |

FIRST NAME _____ M.I. _____ LAST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () - - - - CELL () - - - - WORK () - - - -

SS# _____ AGE _____ DOB _____ / _____ / _____

DRIVERS LICENSE # _____ MALE _____ FEMALE _____

E-MAIL ADDRESS: _____

EMPLOYER _____ OCCUPATION _____

MARRIED _____ SINGLE _____ DIVORCE _____ NAME OF SPOUSE _____

EMERGENCY CONTACT _____ TEL () - - - -

REFERRED BY _____ FRIEND / RELATIVE / INS / OTHER _____

> PRIMARY INSURANCE Cash _____ Group _____ Work/Comp _____ Automobile _____ Other _____

Name of Insurance Co. _____ ID No. _____ Group # _____

Name of Insured _____ Relationship to Patient: SELF / SPOUSE / PARENT

Secondary Insurance _____ Name of Insured _____

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print) _____ Patient Signature _____ Date _____

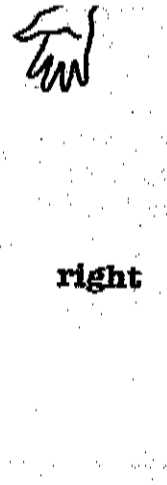
> 24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

PRC takes pride in the quality of care we offer our patients. In order to do this we have a strict cancellation policy. Please read and sign below. PRC requires a 24-hour cancellation notice prior to your appointment time. If sufficient notice is not given, a fee of \$35 will be charge to the credit card we have on file.


I, _____ authorize Pain Relief Center to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

_____ Ex _____ / _____ VISA / MC

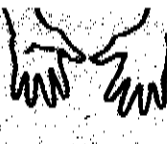
Patient Name (print) _____ Patient Signature _____ Date _____




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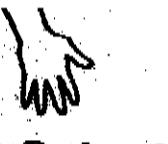
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Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:

(_____)

0 no pain 10 severe pain

Date: _____

Signature _____

Have you had any surgery to replace hip, knee, etc.? _____ Year _____

Give dates you have had any of the following? (if exact date is unknown, give approximate)

Blood tests _____ Urinalysis _____

MRI _____ CT Scan _____ Ultrasound _____

Radiation Treatment _____ X-Ray examination _____

Other special treatment _____

At what hospital or office were these tests taken _____

Name of doctor who ordered tests _____

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes _____ No _____

Do you have any health problems not listed above? _____

Do you wish to have a third person or chaperone present during your examination and treatment? Yes _____ No _____

Do you faint easily? _____

Do you take vitamins? Yes _____ No _____ If yes, please list them _____

Do you exercise regularly? Yes _____ No _____ What kind of exercise? _____

Habits: (please check)

Cigarettes _____ Quantity _____ Coffee? _____ Quantity _____

Alcohol? _____ Quantity _____ Tea? _____ Quantity _____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____
If yes, what condition? _____

Have you lost or gained weight in the past year? _____

Use this space for any additional information you may wish to discuss _____

Have you lost any work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes _____ No _____

Will this case be covered by any insurance company? Major Medical _____ Auto _____

Blue Cross/Blue Shield _____ Workers' Compensation _____ Medicare _____ Other _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.
(even as a child)? _____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication, herbs, or over the counter products
(aspirin included)? Yes _____ No _____

If yes, name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you ever had any cosmetic surgery, breast implants, etc.? _____ Year _____



Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now (within the past 12 months) or P if you ever had these conditions in the past.

| | Now | Past | | Now | Past |
|---------------------------|-------|-------|------------------------|-------|-------|
| | N | P | | N | P |
| Headaches _____ Frequency | _____ | _____ | Loss of Balance | _____ | _____ |
| Neck Pain | _____ | _____ | Fainting | _____ | _____ |
| Stiff Neck | _____ | _____ | Loss of Smell | _____ | _____ |
| Sleeping Problems | _____ | _____ | Loss of Taste | _____ | _____ |
| Back Pain | _____ | _____ | Diarrhea | _____ | _____ |
| Nervousness | _____ | _____ | Feet Cold | _____ | _____ |
| Tension | _____ | _____ | Hands Cold | _____ | _____ |
| Irritability | _____ | _____ | Arthritis | _____ | _____ |
| Chest Pains | _____ | _____ | Muscle Spasms | _____ | _____ |
| Dizziness | _____ | _____ | Frequent Colds | _____ | _____ |
| Shoulder/Neck/Arm Pain | _____ | _____ | Stomach Upset | _____ | _____ |
| Pins & Needles in Arms | _____ | _____ | Constipation | _____ | _____ |
| Pins & Needles in Legs | _____ | _____ | Cold Sweats | _____ | _____ |
| Numbness in Fingers | _____ | _____ | Fever | _____ | _____ |
| Numbness in Toes | _____ | _____ | Sinus Problems | _____ | _____ |
| High Blood Pressure | _____ | _____ | Diabetes | _____ | _____ |
| Difficulty Urinating | _____ | _____ | Hemorrhoids | _____ | _____ |
| Allergies | _____ | _____ | Leg Cramps | _____ | _____ |
| Weakness in Arms | _____ | _____ | Colitis | _____ | _____ |
| Weakness in Legs | _____ | _____ | Gall Bladder | _____ | _____ |
| Shortness of Breath | _____ | _____ | Indigestion | _____ | _____ |
| Fatigue | _____ | _____ | Belching | _____ | _____ |
| Depression | _____ | _____ | Vomiting | _____ | _____ |
| Lights Bother Eye | _____ | _____ | Shoulder Pain | _____ | _____ |
| Loss of Memory | _____ | _____ | Swelling Joints | _____ | _____ |
| Ears Ring | _____ | _____ | Knee Pain | _____ | _____ |
| Face Flushed | _____ | _____ | Hayfever | _____ | _____ |
| Buzzing in Ears | _____ | _____ | Menstrual Difficulties | _____ | _____ |

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____