



**PATIENT
REGISTRATION**

Physician _____
Date: _____ Int: _____
Account # _____

Name: _____
Last First MI Home Phone Work Phone

Address _____ City State Zip Code

Email Address _____ Do you live alone? Yes No Birthdate _____ Age _____

Sex: Male Female Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian or Alaska Native Black or African American Native Hawaiian or Other Pacific Islander
 Asian White Unknown / Other

Occupation _____ Employer _____ Length of employment _____

Business Address _____

Name of Spouse or Parents _____

Referring Physician

Phone _____

Primary Care Physician

Phone _____

Which is your preferred hospital, if a procedure is required? _____

CURRENT CHIEF COMPLAINT:

When did your pain start? _____ Date of injury _____ How did symptoms start _____

Pain began: Suddenly Gradually Chronic Related to: Job Accident Unsure Other: _____

CURRENT MEDICAL PROBLEMS (Check all that apply):

- AIDS / HIV
- Arthritis / Gout
- Asthma
- Bleeding Condition
- Blood clots / DVT
- Cancer (Type/Location)
- Diabetes – Type I or Type II
- Depression
- Emphysema / COPD
- Glaucoma
- Heart Disease or Heart Attack
- High Blood Pressure
- Irregular Heartbeat
- Liver or Kidney Problems
- Neuropathy
- Osteoporosis
- Pacemaker or heart valve
- Pancreatitis
- Seizures
- Stroke
- Thyroid Disease
- Ulcers or Reflux
- Other _____

MEDICAL HISTORY:

List Surgeries (include dates):

1. _____
2. _____
3. _____
4. _____

Medications you are currently taking:

(include dosage, supplements and over the counter drugs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Other Illnesses requiring hospitalizations (include dates):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medication Allergies Yes No. If yes, please list:

1. _____
2. _____
3. _____

Are you allergic to ADHESIVE TAPE? Yes No.

Are you allergic to LATEX? Yes No.

Are you allergic to CTContrast/ Kidney Dye/ Iodine Yes No.

Are you allergic to Gadolinium/ MRI Contrast? Yes No.

Pharmacy Name: _____ Phone: _____

May we have consent to access your medication history? Yes No.

REVIEW OF SYSTEMS: Please check YES or NO if you have had these in the last 6 months:

		Y	N			Y	N			Y	N
Constitutional:	Recurrent fevers			Fatigue			Weight loss / gain				
Skin:	Rash			Ulceration			Excessive dryness				
Hematologic:	Bruising			Easy bleeding			Swollen glands				
Endocrine:	Tremors			Hair loss			Generalized weakness				
Eyes:	Blurry			Dry eyes			Excess tearing				
ENT:	ringing ears			Bloody noses			Trouble swallowing				
Cardio:	Chest pain			Racing heart			Leg swelling				
Respiratory:	Coughing			Congestion			Short of breath				
GI:	Tarry stools			Bloody stools			Abdominal pain				
Urinary:	Frequency			Blood urine			Burning				
Allergies / Immun:	Asthma			Hives			Hay fever				
Mus / Skeletal:	Muscle pain			Joint pain			Joint swelling				
Neurological:	Dizziness			Facial pain			Headaches				
Psychiatric:	Depression			Anxiety			Mood Swing				

Physician _____ Date: _____

Int: _____ Account # _____

IMMEDIATE FAMILY HISTORY:

Do you live with your spouse? Yes No Do you have children? Yes No. If so, list below

CHILDREN	AGE	HEALTH	PROBLEM
_____	_____	<input type="checkbox"/> Good	_____
_____	_____	<input type="checkbox"/> Good	_____
_____	_____	<input type="checkbox"/> Good	_____
_____	_____	<input type="checkbox"/> Good	_____
_____	_____	<input type="checkbox"/> Good	_____

Do any blood relatives have the following major health problems? If yes, Who?

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Migraine headaches _____ |
| <input type="checkbox"/> Aneurysm / Brain _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Neurofibromatosis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Polycystic kidney _____ |
| <input type="checkbox"/> Bladder disease _____ | <input type="checkbox"/> Heart problem _____ | <input type="checkbox"/> Psychological disorder _____ |
| <input type="checkbox"/> Blood vessel disease _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Spina bifida _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Lung disease _____ | <input type="checkbox"/> Stroke _____ |
| Type: _____ | Type: _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Degenerative disc disease _____ | | |

Are there any hereditary diseases in your family that you are aware of? Yes No. If yes, please list: _____

SOCIAL HISTORY:

Marital Status: Married Separated Divorced Single Widowed

Tobacco Use: None Smoke _____ pack per day _____ Years smoked Chewing Tobacco / Snuff Cigars

Did you ever smoke? Yes No If yes, when did you quit? _____

Alcohol use: None Occasional / Social Daily

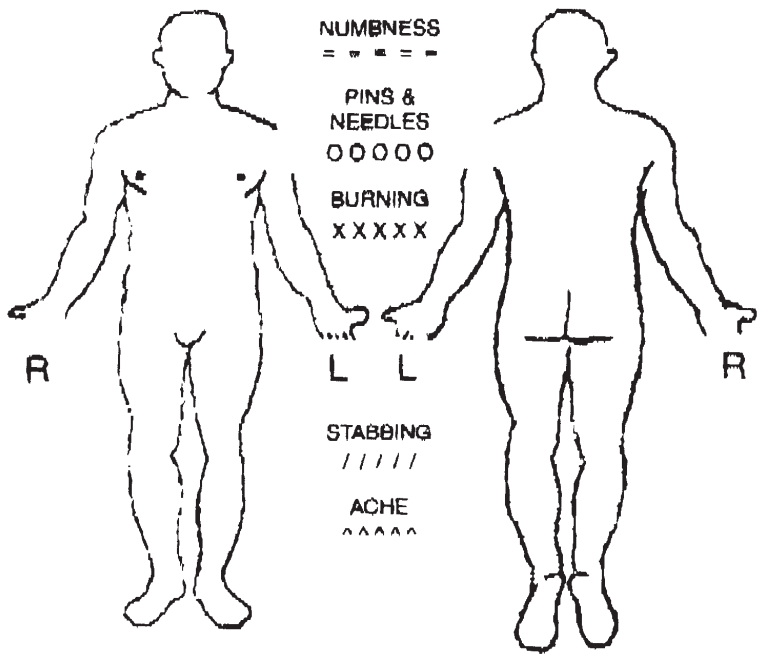
Are you pregnant? Yes No Is it possible that you could be pregnant? _____

Height _____ Weight _____ One year ago? _____ Maximum weight? _____ When? _____

Hand Preference: Right Left

FOR SPINE PATIENTS ONLY — WHERE IS YOUR PAIN NOW:

Mark all that apply:



- | | | |
|---------------------|--------------------------|--------------------------|
| | worse | better |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying down | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing / Sneezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Rising from sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Remedy | <input type="checkbox"/> | <input type="checkbox"/> |

VISUAL ANALOG SCALE

Please indicate on the scale below your level of pain with 10 being the worst. Use an "X" to indicate your most severe pain, and use an "O" to indicate your average amount of pain.

RATE YOUR PAIN

None 0 1 2 3 4 5 6 7 8 9 10 Worst

Pain in arm(s) / leg(s) compared to neck / back: More than Same as Less than

Is there weakness of your arms / legs? Yes No

How long can you sit with no / minimal pain? _____ How long can you stand with no / minimal pain? _____

How far can you walk with no / minimal pain? _____

Have you had trouble controlling your bowels or bladder? Yes No If yes, is this a new problem? Yes No

In the past twelve months, have you had Physical Therapy, Chiropractic, Medications, Steroid Injections or Imaging studies for your pain?

Yes No If yes, please check below and include last date of treatment.

<input type="checkbox"/> None	Dates of treatment _____	<input type="checkbox"/> Discogram	Dates of treatment _____	<input type="checkbox"/> Non-narcotic meds	Dates of treatment _____	<input type="checkbox"/> Pain Management	Dates of treatment _____
<input type="checkbox"/> MRI	_____	<input type="checkbox"/> EMG / NCS	_____	<input type="checkbox"/> Narcotic meds	_____	<input type="checkbox"/> Holistic Medicine	_____
<input type="checkbox"/> CT	_____	<input type="checkbox"/> Bloodwork	_____	<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/> Massage Therapy	_____
<input type="checkbox"/> Myelogram	_____	<input type="checkbox"/> Epidural	_____	<input type="checkbox"/> Chiropractic	_____	<input type="checkbox"/> Acupuncture	_____
<input type="checkbox"/> X-Rays	_____	<input type="checkbox"/> Facet Block	_____	<input type="checkbox"/> Traction / Decompression	_____	<input type="checkbox"/> Bracing	_____
<input type="checkbox"/> Bone Scan	_____	<input type="checkbox"/> Steroid Injections	_____	<input type="checkbox"/> Exercise Program	_____	<input type="checkbox"/> Tens Unit	_____
	Describe/ List _____		Dates of treatment _____		Describe/ List _____		Dates of treatment _____
<input type="checkbox"/> Other	_____		_____	<input type="checkbox"/> Other	_____		_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature _____

Date: _____ Physician's Signature _____