



DEMOGRAPHICS FORM

Today's Date: _____

Please read these sheets carefully and answer all questions to the best of your ability. This will assist us in better treating your pain. Thank you for your time and cooperation.

Name: _____

Age: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Home # _____ Cell # _____ Work # _____

Address: _____

Email Address: _____

Referring Physician(s): _____

Other Physicians seen for this problem: _____

Marital Status: S M D W Other Ethnicity: Hispanic _____ Not Hispanic _____

SS# _____ - _____ - _____ Race: _____ Preferred Language _____

Spouse/Significant Other Name: _____ Phone #: _____

Your Employer: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Primary Insurance: _____

Subscriber ID #: _____ Group #: _____

Policyholder: _____ Phone #: _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Your Secondary Insurance: _____

Subscriber ID #: _____ Group #: _____



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Policy holder: _____ Phone #: _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Is this a Workman's Comp. Claim? Yes No If Yes, Complete WC Form

Is this a Car accident claim? Yes No If Yes, Complete MVA Form

Authorization to release Information and Assignment of Benefits:

I hereby assign all medical and /or surgical benefits to which I am entitled, including Medicare, BCBS, HMO's and all commercial insurances to the above named providers and their facilities. I understand that I am fully responsible for all charges whether or not they are covered by my insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf. I understand I am totally responsible for all charges on my account, I understand that this office will file claims with my insurance and that I am responsible for any amount not paid. If this account has to be collected by an attorney or/ and a collection agency I understand that I will be responsible for the attorney or and the collection agency fees also. I authorize release of my medical information to my physician and insurance carrier including Medicare. I also authorize payment of benefits directly to my physician. I also give permission to take an identification photograph to be maintained in my medical records, I understand that this picture will be used in a confidential manner related only to my personal care in the above mentioned office

Patient name: _____ Patient Signature: _____

Today's Date: _____

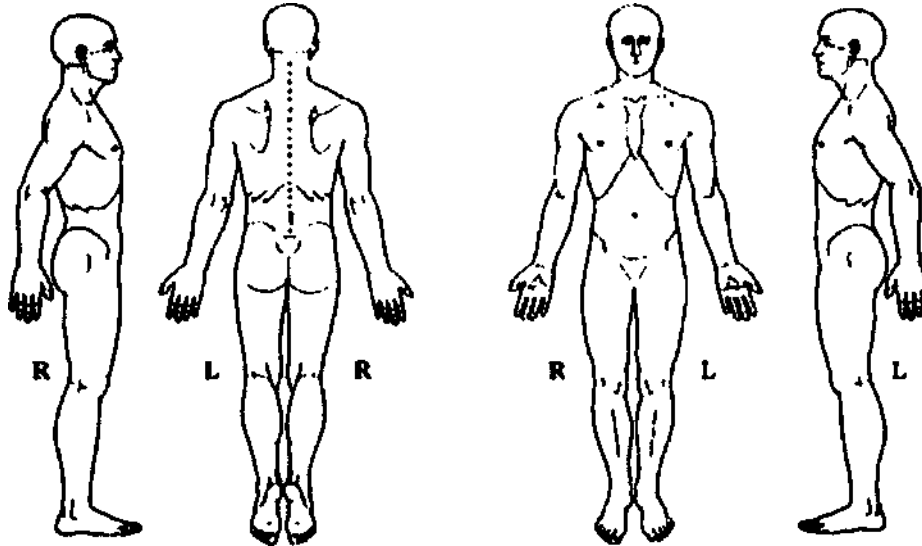


PAIN QUESTIONNAIRE

Name: _____ Today's Date: _____

Where is your pain: _____

Please mark on the diagrams where your pain is located.



- Neck Pain level : (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Mid Back pain level : (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Lower Back pain level: (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Headache Pain level: (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Other Location _____: (0-10) 0 1 2 3 4 5 6 7 8 9 10

Does your pain radiate anywhere? _____

Shooting down the right or left arm

shooting down right or left leg

When did the pain start?

Please circle the appropriate words that best describe your pain.

ACHING

DULL

SHOOTING

NUMBING

BURNING

TIGHT

CRAMPING

TINGLING

SORENESS

STABBING

COLDNESS

SHARP



Past Medical History

- **Heart** Coronary artery disease Hypertension Murmurs High cholesterol
 Valvular disease Aneurysm Pacemaker Heart failure Other
- **Lungs** Asthma COPD Emphysema TB Lung cancer Other
- **Gastrointestinal** Ulcer Reflux Gastritis Hepatitis Bleeding Diverticulosis other
- **Genitourinary** Kidney stones Renal Failure Dialysis (when) _____ Other
- **Endocrine** Hypothyroidism Hyperthyroidism Diabetes Parathyroid Problem
- **Neuro** Stroke Nerve injury spinal cord injury Dementia Seizures Other
- **Psychiatric** Depression Anxiety Panic attacks OCD Bipolar
 Other _____

- **Musculoskeletal** Arthritis Rheumatoid arthritis Osteoarthritis Gout Osteoporosis
 Scoliosis
- **Other** _____

Past Surgery History:

Allergies:

Latex No Yes Reaction _____ Contrast (Dye) No Yes Reaction _____

Allergy to any medication (s)? _____

Current Medications:

Social History:

Tobacco: Never Quit in _____ Currently _____ pack per day

Alcohol: Never Rarely Moderate Daily

Use of drugs: Never Occasionally Frequently



Significant Family History: (Cancer, Hypertension, Diabetes, Depression, back pain...)

- Father side _____
- Mother side _____

Review of Systems

- **Gen** Weight loss Weight gain Fever fatigue Loss of appetite Nausea
 Vomiting
- **Skin** Skin problems Rash Psoriasis Slow healing Itching Easy bruising
- **Neuro** dizziness Fainting Weakness Stroke Tremor Seizure Memory loss
- **Eyes** Vision problem Glaucoma Blurred Vision Double Vision
- **ENT** Ear Pain Hearing loss Ear noises Nose Bleed Sore throat Hoarseness
 Dental Problems
- **Cardiovascular** Chest Pain Shortness of breath Irregular heart beat Murmurs
- **Respiratory** Coughing Difficulty breathing Asthma/Wheezing Coughing up blood
- **Gastrointestinal** Constipation Diarrhea Heart burn Pain in stomach Ulcers Hepatitis
- **Genitourinary** pain urination Frequent urination Kidney stone
 Sexual difficulty Infection
- **Endocrine** Hypothyroidism Hyperthyroidism Diabetes Parathyroid Problem
- **Hematology** Anemia Bleeding disorder Easy Bleeding Lymphoma/ Leukemia
- **Immunologic** HIV/AIDS Fever Hay Fever Frequent sinus problems Allergies
- **Musculoskeletal** Arthritis Rheumatoid arthritis Osteoarthritis Compression fracture
 Head Injury Neck injury Low back injury Spinal trauma Gout
 Osteoporosis Muscular dystrophy Muscle Pain Scoliosis
- **Psychiatric** Depression Anxiety Panic attacks OCD Bipolar Homicidal
 Suicidal attempts Suicidal ideation psychosis Hallucination other

Patient Name: _____

Patient Signature: _____ Today's Date: _____