PATIENT INFORMATION FORM

(OFFICE USE ONLY)

PI ACUPUNCTURE CASH WC PT INSURANCE

Patient File # ____________________ **Doctors Name #** ______________________________________

First Name ________________________ M.I.___ Last Name ______________________________

Birth Date ____/____/____ Age ____ Marital Status (S M W D)Spouse ___________

SEX ____ SSN _____/____/_______ Driver' Lic. No. __________________ State ____

Address _____________________________________ City _____________________

State ______ Zip __________ Home Phone ( ) ______________________________

Work Phone ( ) ____________________ Cell Phone ( ) ____________________

Email ______________________________

Employer ___________________________ Referred By ______________________

Primary Insurance Co. ______________________Policy # ______________________

Secondary/ Other Insurance Co. _________________________

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

Patient Signature ___________________________________ Date ______/______/_________

HISTORY FORM

1. Chief Complaint: ______________________________

Complaint Began when and how? ______________________________

Have you had this pain before? ______________________________

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other ____________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?______________________________

Do you have any numbness or tingling in your body? Where? ______________________________

How frequent is complaint present, how long does it last? ______________________________

Is your complaint getting better, getting worse, or unchanged since it began? ______________________________

Is there any daily activity you have difficulty with or can no longer do? ______________________________

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Does anything aggravate the complaint? ______________________________

Does anything make the complaint better? ______________________________

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

3. Past Health History:

A. Previous illnesses you've had in your life: ______________________________

B. Previous injury or fractures: ______________________________

C. Allergies ______________________________

D. Medications:

Medication	Reason for taking
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

E. Surgeries:

____

4. Family Health History:

Associated health problems of relatives: ______________________________

Deaths in immediate family:

Cause of parents or siblings death	Age at death
______________________________	____________
______________________________	____________
______________________________	____________

5. Social and Occupational History:

A. Job physical demands: ______________________________

B. Recreational activities: ______________________________

C. Sleeping position: ______________________________

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):______________________________

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Doctors Signature ______________________________ Date ______________________________