

Practice: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

*E-mail newsletters, reminders, statements, etc.*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to Insured:  Spouse  Child  Self  other

Phone #: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to Insured:  Spouse  Child  Self  Other

Phone #: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you find out about our practice?  Physician  Internet  Telephone book  Family member  Friend

Other: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

How long has this bothered you? 1 2 3 4 5 6 7  days  weeks  months  years

What treatments have you tried & have they been effective? \_\_\_\_\_

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? \_\_\_/10

The pain quality is:  burning  constant  dull  sharp  shooting  throbbing  tingling Other: \_\_\_\_\_

**PLEASE READ AND SIGN**

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_