

# Patient Health History

Date:

## PATIENT INFORMATION

How did you hear about Richmond Spine and Rehab?

\_\_\_\_\_

Patient Title: (check one):  Mr.  Mrs.  Ms.  Miss.  Dr.

First Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_  Cell  Home  Work

Secondary Phone Number: \_\_\_\_\_  Cell  Home  Work

Emergency Contact Phone Name & Number: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

*By providing the phone numbers and emails, I authorize my doctors' representatives to contact me via the provided information.*

Which email address would you like us to use to communicate with you?  Home  Work

Contact Method (check one):  Primary Phone  Secondary Phone  Home Email  Work Email

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Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Single  Married  Other

Employment Status:  Employed  FT Student  PT Student  Retired  Self-Employed  Other

Name of Employer: \_\_\_\_\_

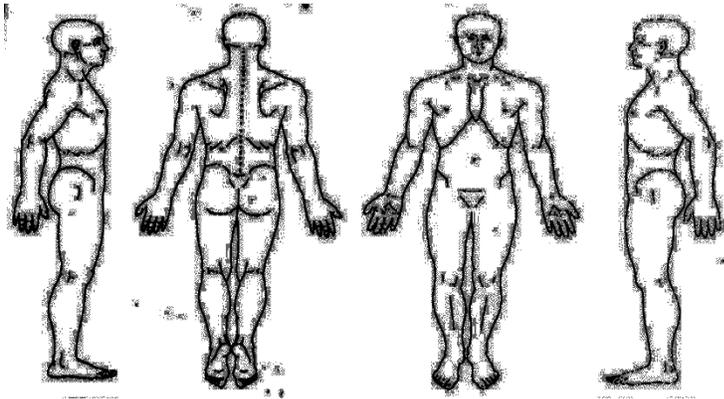
Patient Condition

Reason for visit \_\_\_\_\_

When did your symptoms begin \_\_\_\_\_

Is this condition getting worse?  Yes  No  Unknown

Indicate on the picture where you have pain, numbness, or tingling.



List pain in order of Severity by location and ranking greatest to least:

- 1.
- 2.
- 3.
- 4.

Rate the severity of your pain from 0 no pain to 10 severe

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other \_

\_\_\_\_\_

How often is the pain during the day?

- Constant (76-100%)       Frequently (51-75%)
- Occasionally (26-49%)     Intermittently (0-25%)

Does it interfere with  Work  Sleep  Daily Routine  Recreation

What activities or movements are painful to perform? \_\_\_\_\_

\_\_\_\_\_

What activities or movements make the pain better? \_\_\_\_\_

\_\_\_\_\_

What is the pain stopping you from doing in your daily life? \_\_\_\_\_

\_\_\_\_\_

Have you had any surgeries or are you on any current medication? \_\_\_\_\_

\_\_\_\_\_

Circle Y or N for all current conditions below .

Y	N	FEVER
Y	N	CHILLS
Y	N	FAINTING
Y	N	LOSS OF FOCUS
Y	N	JOINT STIFFNESS
Y	N	BACK PAIN
Y	N	JOINT SWELLING

Y	N	IRRITABILITY
Y	N	DEPRESSION
Y	N	MEMORY LOSS
Y	N	HEADACHE
Y	N	MUSLCE PAIN
Y	N	MUSCLE WEAKNESS
Y	N	MUSCLE CRAMP

Y	N	STIFF NECK
Y	N	SEIZURES
Y	N	DIZZINESS
Y	N	LOSS OF SENSATION
Y	N	LOSS OF COORDINATION
Y	N	PARALYSIS
Y	N	DIFFICULTY OF SPEECH

Accident Information

Is this condition due to an accident? Yes /No (date)\_\_\_\_\_

Type of accident Auto/ Work /Other\_\_\_\_\_

To whom have you made a report of your accident?

Auto Insurance /Employer/ Worker Comp/Other

Attorney Name (if applicable)\_\_\_\_\_

Claim Number\_\_\_\_\_

Claim Address\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Alt. Phone \_\_\_\_\_ ext \_\_\_\_\_

For Auto Accident

Auto Carrier \_\_\_\_\_

Policy No. \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Date of Loss \_\_\_\_\_

Adjuster Name & Phone Number: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

*I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and sign directly to Richmond Spine and Rehab all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

\_\_\_\_\_

**Responsible Party Signature**