

PATIENT HISTORY FORM

Name: _____

Date _____

1. What are your **major complaint(s)**? _____

2. Does the pain you are experiencing **travel** to any other part of your body? (If yes please describe)

3. On the scale below, please **circle** the **severity** of your **main complaint** (at its worst):

None			Slight			Mild			Moderate			Severe
1	2	3	4	5	6	7	8	9	10			

4. On the scale below, please circle the **percentage of time** you experience your **main complaint**:

Occasional		Intermittent			Frequent			Constant	
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

5. How **long** have you been experiencing your **main complaint**? Days Weeks Months Years

6. When do you notice your complaint or complaints the most? AM PM BOTH

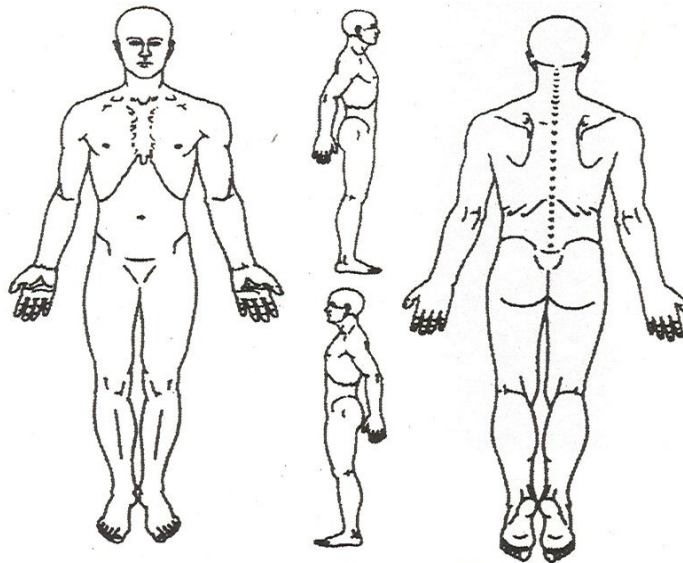
7. How long does it last? _____ Minutes _____ Hours

8. What makes it feel **worse**? Sitting Standing Lying Activity Other _____

9. Have you ever had this problem in the past? Yes No

10. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B: burn** **T: tingling** **N: numbness** **S: sharp** **C: cramping** **D: dull pain**



PATIENT REGISTRATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

SS# _____ DOB: _____ Age: _____ Gender: _____

Home Phone # _____ Work # _____ Cell # _____

Occupation _____ Employer's Name: _____

Employer's Phone: _____ Marital Status S M W D

Spouse's Name: _____ Spouse's Employer _____

Spouse's D.O.B. _____

Emergency Contact _____ Phone # _____

How many children do you have? _____ What are their ages? _____

Have they or any other members of your family received Decompression Therapy? Yes No

Have you ever received Decompression Therapy? Yes No When was your last visit? _____

Reason for today's visit? _____

Referred By: _____

How often do you drink alcoholic beverages? _____

Do you smoke? Yes No How much? _____

Do you exercise? Yes No How often? _____

Do you have any allergies? (specify) _____

Have you been diagnosed as having: (circle yes or no for each)

Y N *Broken/Fractured Bones Y N *Osteoarthritis Y N Eating Disorder

Y N Circulatory Problems Y N Epilepsy Y N Alcoholism

Y N *Rheumatoid Arthritis Y N Pacemaker Y N Drug Addiction

Y N Seizures/Convulsions Y N Strokes Y N HIV Positive

Y N A Congenital Disease Y N *Cancer Y N Gall Bladder

Y N Excessive Bleeding Y N Ulcers Y N *Head Problems

Y N High/Low Blood Pressure Y N Ruptures Y N Depression

Y N *Diabetes Y N Coughing Blood Y N Tumors

*Explanation _____

Any accidents of any kind? _____

Medications currently taking? _____

IMPORTANT: Please check (x) all present symptoms.

HEAD:

- Headache
 - Sinus (allergy)
 - Entire head
 - Back of head
 - Forehead
 - Temples
 - Migraine
- Head feel heavy
- Loss of memory
- Light-headed
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of balance
- Loss of taste
- Loss of hearing
- Dizziness
- Pain in ears
- Ringing or noises in ears

NECK:

- Pain in neck
- Neck pain with movement
 - Forward
 - Backward
 - Turning (L) (R)
 - Bending (L) (R)
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS:

- Pain in joint (L) (R)
- Pain across shoulders
- Bursitis (L) (R)
- Arthritis (L) (R)
- Can't raise arm
 - Above shoulder level
 - Over head
- Tension in shoulders
- Pinched nerve in shoulder (L) (R)
- Muscle spasms in shoulder

ARMS AND HANDS:

- Pain in arm
- Tennis elbow

- Pain in hands/fingers (L) (R)
- Pins and needles sensation (L) (R)
- Numbness (L) (R)
- Hands cold
- Loss of grip strength
- Sore/swollen joints in fingers
- Arthritis in fingers

MIDBACK:

- Mid-back pain
- Location
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Muscle spasms
- Pain in Kidney area

CHEST:

- Chest pain
- Shortness of breath
- Rib pain
- Breast pain
- Dimpled orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Lower back pain
 - Upper lumbar
 - Lower lumbar
 - Sacroiliac
- Low back pain is worse when
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying down
 - Walking
- Pain relieved when _____
- Slipped disc
- Low back feels out of place

- Muscle spasms
- Arthritis

HIPS, LEGS, & FEET

- Pain in buttocks (L) (R)
- Pain in hip joint (L) (R)
- Pain down leg (L) (R)
- Knee pain (L) (R)
 - Outside
 - Inside
- Leg cramps
- Feet cramps
- Pins and needles in legs
- Numbness in legs/feet
- Swelling in legs/feet

WOMEN ONLY:

- Menstral pain
- Cramping
- Irregularity
- Cycle _____ Days
- Birth control _____ type
- Hysterectomy
- Tumors/Cancer _____
- Discharge
- Menopause _____
- Abortions
- Are you pregnant

MEN ONLY:

- Urinary frequency
- Difficulty starting
- Night urination
- Prostate swelling

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Run-down feeling
- Normal sleep _____ Hrs
- Loss of sleep
- Loss of weight _____ Lbs
- Weigh gain _____ Lbs
- Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Diabetes
- Hypoglycemia

REMARKS:

Patient Signature: _____ Date: _____



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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Spinal Decompression Centers of Central Florida, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Spinal Decompression Centers of Central Florida, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Spinal Decompression Centers of Central Florida, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Spinal Decompression Centers of Central Florida, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date