INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**.

Today's Date _____

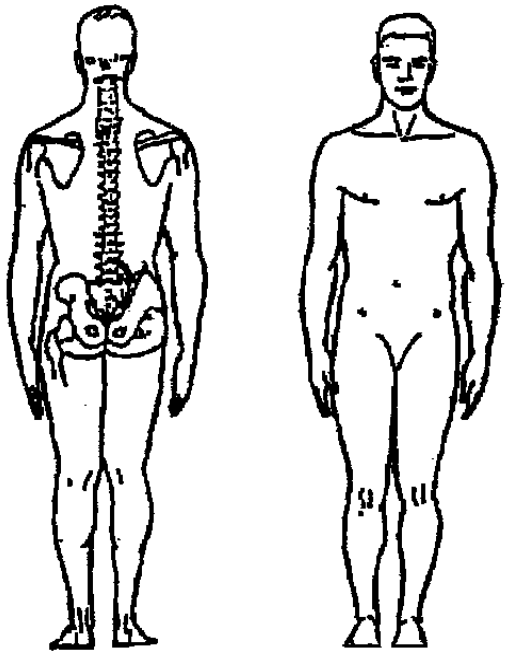
Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Your Social Security # _____
Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____
Name of Spouse or Parent _____ Their Phone Number_____ Their Birthdate _____
Referred to our office by: _____

How payment will be made following today's visit: ☐ Cash ☐ Credit Card ☐ Check ☐ Automobile Insurance Policy

Please describe your major concerns and mark them on the diagram →

_____
_____



A. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

B. Frequency
- ☐ Constant (75-100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (25 - 50%)
- ☐ Intermittent (25% or less)

C. How long have you been experiencing these symptom(s)
- ☐ Days ☐ Months
- ☐ Weeks ☐ Years

-how many ____

D. On the scale below indicate the intensity of your pain at its lowest and highest level:

1 2 3 4 5 6 7 8 9 10

D. Your symptoms are: _____decreasing _____not changing _____increasing
E. Symptoms are worse in the: _____Morning _____Night _____Increases during the day _____Same all day

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Notice to our new patients: *Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.*

Patient or Guardian Signature _____ Date _____