



**B. COMPLAINTS (CONTINUED)**

7. Are You Getting?  Better  Worse  Same

8. If Your Complaints Include Pain, Is It Aggravated By?

- Coughing
- Sneezing
- Straining At Stool
- Neck Movement
- Reaching
- Lifting
- Bending
- Sitting
- Standing
- Walking
- Other

9. If Your Complaints Include Pain, Is It Relieved By?

- Nothing
- Rest
- Ice
- Heat
- Stretching
- Exercise
- Sitting
- Standing
- Other

10. Have You Had Recent Treatment For This Condition?

Yes  No If Yes, List Dates, Treatments, And Doctors:

\_\_\_\_\_

\_\_\_\_\_

11. Has This Condition Existed In The Past?  Yes  No

12. Since Your Symptoms Began, Have You Noticed A Change In? If Yes, Indicate

	Onset Date	Duration
<input type="radio"/> Bowel Function		
<input type="radio"/> Bladder Function		
<input type="radio"/> Sexual Function		

**C. REVIEW OF SYSTEMS**

1. Are You Presently Suffering (Or Within The Past Six Months Suffered) From Any Of The Following?

a. General

- Normal
- Fatigue
- Weakness
- Fever
- Loss Of Sleep
- Chills
- Weight Change
- Night Sweats
- Other

b. Skin

- Normal
- Rash
- Redness
- Itching
- Dryness
- Eczema
- Hair Changes
- Nail Changes
- Bruise Easily
- Other

c. Neurologic

- Normal
- Headache
- Dizziness
- Fainting
- Convulsions
- Nervousness
- Other

d. Eyes

- Normal
  - Vision Trouble
  - Pain
  - Discharge
  - Other
- |  |                       |                       |       |
|--|-----------------------|-----------------------|-------|
|  | Right                 | Left                  |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> | Right |
|  |                       |                       | Left  |

e. Ears

- Normal
  - Hearing Trouble
  - Ringing
  - Pain
  - Discharge
  - Other
- |  |                       |                       |       |
|--|-----------------------|-----------------------|-------|
|  | Right                 | Left                  |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> |       |
|  | <input type="radio"/> | <input type="radio"/> | Right |
|  |                       |                       | Left  |

f. Nose

- Normal
- Pain
- Bleeding
- Sinus Problems
- Infections
- Absence Of Smell
- Other

g. Mouth/Throat

- Normal
- Sores
- Bleeding
- Enlarged Glands
- Absence Of Taste
- Abnormal Taste
- Tonsillitis
- Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)

- Normal
- Cough
- Wheezing
- Difficulty Breathing
- Swollen Extremities
- Blue Extremities
- Varicosities
- Murmur
- Chest Pain
- Palpitations
- Other

i. Breasts

- Normal
- Lumps In Breast(s)
- Redness/Itching
- Pain
- Dimpling
- Discharge
- Other

j. Gastrointestinal (Stomach/Digestion)

- Normal
- Decreased Appetite
- Increased Appetite
- Abdominal Pain
- Hemorrhoids
- Excess Gas
- Vomiting
- Diarrhea
- Constipation
- Other

k. Genitourinary

- Normal
- Inability To Hold Urine
- Painful Urination
- Frequent Urination
- Bedwetting
- Irregular Menstruation
- Painful Menstruation
- Abnormal Vaginal Bleeding
- Impotence
- Sterility
- Prostate Problems
- Other

l. Endocrine (Metabolism)

- Normal
- Heat/Cold Intolerance
- Sugar In Urine
- Goiter
- Tremor
- Other

m. Psychologic

- Normal
- Anxiety
- Depression
- Memory Loss Or Impairment
- Phobias
- Mood Swings
- Other

NO MARKS HERE NO MARKS HERE NO MARKS HERE



**E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)**

- 5. Job Involves**
- a. Lifting** .....  10  20  30  40  50  60  70  80  90  100+ Pounds
- Never  Frequently  
 Occasionally  Constantly
- b. Additional Job Requirements**
- Bending  Twisting  Carrying  
 Stooping  Turning  Walking  
 Other \_\_\_\_\_
- 6. What Is Your Primary Work Position \ Location?**
- a. Position:**  Seated  Standing  Other \_\_\_\_\_
- b. Location:**  Desk  Counter  Workbench  Other \_\_\_\_\_
- c. If Seated, What Type Of Chair Do You Use?**
- Executive  Steno  Bench  Stool  Other \_\_\_\_\_
- 7. Do You Wear Shoes Or Boots With High Heels?**
- Never  Seldom  Occasionally  Frequently
- 8. Are You Right Or Left Handed?**
- Right  Left
- 9. Do Work Activities Aggravate Your Present Complaints?**
- Yes  No
- 10. Which Of The Following Best Describes Your Stress Level?**
- None  Minimal  Moderate  Great
- 11. How Do You Rate Your Physical Activity At Work?**
- Seated more than 50% of workday  
 Light Manual Labor  
 Moderate Manual Labor  
 Heavy Manual Labor

**F. INSURANCE INFORMATION**

- 1. Is Your Condition Due To:**
- An Automobile Accident .....  Yes  No  
A Personal Injury .....    
A Job Injury .....
- 2. Do You Have Health Insurance** .....  Yes  No
- Company \_\_\_\_\_  
Policy # \_\_\_\_\_
- 3. Is Your Spouse Employed.** .....  Yes  No
- Business Address \_\_\_\_\_  
\_\_\_\_\_
- 4. Is Your Spouse The Primary Insured** .....  Yes  No
- Company \_\_\_\_\_  
Policy # \_\_\_\_\_

- 5. HMO, PPO Plan Coverage** .....  Yes  No
- Company \_\_\_\_\_  
Policy # \_\_\_\_\_
- 6. Are You Covered By Medicare** .....  Yes  No
- Medicare # \_\_\_\_\_
- 7. Authorization To Release Records To Patient's Insurance Carrier**
- Patient or Guardian's Signature \_\_\_\_\_  
\_\_\_\_\_

**G. PAYMENT**

**IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**I WILL BE PAYING TODAY BY:** (If paying by credit card please confirm which cards are accepted by our office.)

- Cash  Check  Visa  
 MasterCard  DiscoverCard  American Express  
 Other \_\_\_\_\_

Account # \_\_\_\_\_  
Expiration Date \_\_\_\_\_

Patient's Signature	Date
_____	_____
Guardian or Spouse's Signature	Date
_____	_____
Doctor's Signature	Date
_____	_____

**Is There Anything Else You Would Like Us To Know?**

Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



NO MARKS HERE NO MARKS HERE NO MARKS HERE