Confidential Patient Case History

Name: _____ DOB:_____ Age:_____

Address: _____ # of children: _____

_____ Marital Status: S M D W

Work #: _____ Spouse's Name: _____

Home #: _____ Spouse's Phone # _____

Cell #: _____

Cell Phone Carrier: _____

Email: _____ Employer:_____

How did you hear about us?

☐Yelp ☐ Zoc Doc ☐ Facebook ☐ Community Events ☐Referred by: _____

<u>Health Information:</u>

What is your major complaint?:_____

Other Complaints:_____

How long have you had this condition?:_____

Have you had this or similar condition in the past?:_____

What activities aggravate your condition?:_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐Constant ☐Comes & Goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

How long has it been since you really felt good?_____

Other doctors who have treated this condition:_____

List any surgical operations and year performed:_____

_____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills

☐ Tranquilizers ☐ Insulin ☐ Birth Control ☐ Other_____

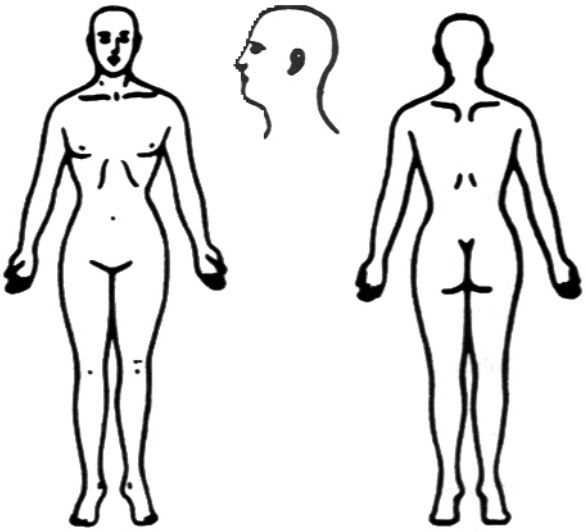
Age of mattress: _____ ☐ Comfortable ☐Uncomfortable

Are you wearing: ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Arch Supports

Have you been in an auto accident? ☐Past Year ☐ Past 5 years ☐ Never

Please Describe: _____

Date of Last Physical Examination _____



Have you ever suffered from?

1. Dizziness	☐ YES	☐ NO
2. Backaches	☐ YES	☐ NO
3. Heart trouble	☐ YES	☐ NO
4. Diabetes	☐ YES	☐ NO
5. Arthritis	☐ YES	☐ NO
6. Headaches	☐ YES	☐ NO
7. Asthma	☐ YES	☐ NO
8. Neuritis	☐ YES	☐ NO
9. Digestive Disorders	☐ YES	☐ NO
10. Nervousness	☐ YES	☐ NO
11. Sinus trouble	☐ YES	☐ NO
12. Neck pain	☐ YES	☐ NO

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐ YES ☐ NO

Do you have health insurance? ☐ YES ☐ NO

Name of Company _____

INSURANCE ASSIGNMENT OF BENEFITS- Payment of Harborside Sport & Spine Bills: I would like a "third party payer" (for example, my insurance company or its related organizations) to pay the bills for my services at Harborside Sport & Spine, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payer" be made to Harborside Sport & Spine on my behalf for services furnished to me by or in Harborside Sport & Spine, I assign the benefits payable to physician services to the physician or organization furnishing the services.

Patient's Signature: _____ Date _____

Guardian or Spouse Signature: _____ SS# _____

Doctor's Signature: _____ Date _____