Date _____ NAME _____ SS# _____ HOME PHONE _____

Mailing Address _____ City _____ Zip Code _____ Cell Phone: _____

Age____ Birth Date _____ Marital M S W D How many Children? ____ E-mail: _____

Occupation _____ Employer _____ Address _____ Work Phone: _____

Nearest relative: _____ Phone: _____ Address: _____

Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Payment : CASH CHECK VISA MASTER CARD HEALTH INS. WORKERS COMP AUTO MED PAY

HEALTH INSURANCE INFORMATION

Insured's Name: _____ Insured's Employer: _____

Insurance Company: _____ Group or Policy #: _____

Address: _____ Insured's SS#: _____ DOB: _____

OR INJURY INFORMATION

Date: _____ Time: _____ Injury reported to Employer? _____

Description of Accident: _____

Name of Workers Comp. Company: _____

Address of Insurance Company: _____

AUTO MED INFORMATION

Your Insurance Company Information:

Insured: _____ Date & Time of Accident: _____

Company Name: _____ Policy No: _____

Address: _____ Claim #: _____

City: _____ State: _____ Med Pay Coverage? YES or NO

Zip: _____ Phone No: _____

Insurance Agent: _____ Phone No: _____

ADDITIONAL INSURANCE INFORMATION

Insured: _____

Company Name: _____ Policy No: _____

Address: _____ Claim No: _____

Insurance Agent: _____ Phone: _____

ATTORNEY INFORMATION

HAVE YOU RETAINED AN ATTORNEY FOR THIS CASE? Yes or No

Name: _____ Phone No: _____

Address: _____ City: _____

State: _____ Zip: _____

_____ _____

Patient Signature Date

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? _____

Do you take birth control? ☐yes ☐no **Have you ever taken birth control in the past?** ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

PALMETTO WELLNESS & INJURY CENTER

PATIENT HISTORY

Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

_____ _____

Patient Signature **Date**

Print Name:_____ Date:_____

Patient Signature:_____

PALMETTO WELLNESS & INJURY CENTER *REVIEW OF SYSTEMS*

Please Check the signs/symptoms related to the following body system you now have or experienced in the past.

Constitutional
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Integumentary
- ☐ Deny All
- ☐ Breast Lumps/ Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair loss
- ☐ History of skin disorders
- ☐ Hives
- ☐ Itching
- ☐ Parathesia
- ☐ Rash
- ☐ Skin Lesions

Neurological
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headaches
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

Allergic/ Immunologic
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Eyes
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

Gastrointestinal
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Psychiatric
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

Cardiovascular
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

Genitourinary
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy/ Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Endocrine
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Hematologic/Lymphatic
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

Musculoskeletal
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

Respiratory
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Sputum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infection
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing Ears
- ☐ TMJ Problems
- ☐ Ulcer

Patient Name: _____ **Date:** _____

Patient Signature: _____

This questionnaire index is designed to enable us to understand how much your **neck pain** has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

Pain Intensity ☐ I have no pain at the moment. ☐ The pain is very mild at the moment. ☐ The pain is moderate at the moment. ☐ The pain is fairly severe at the moment. ☐ The pain is very severe at the moment. ☐ The pain is the worst imaginable at the moment.	**Concentration** ☐ I can concentrate fully when I want to with no difficulty. ☐ I can concentrate fully when I want to with slight difficulty. ☐ I have a fair degree of difficulty in concentrating when I want to. ☐ I have a lot of difficulty in concentrating when I want to. ☐ I have a great deal of difficulty in concentrating when I want to. ☐ I can't concentrate at all.
Personal Care (Washing, Dressing, etc.) ☐ I can look after myself normally without causing extra pain. ☐ I can look after myself normally, but it causes extra pain. ☐ It is painful to look after myself and I am slow and careful. ☐ I need some help, but manage most of my personal care. ☐ I need help every day in most aspects of self care. ☐ I do not get dressed, I wash with difficulty and stay in bed.	**Work** ☐ I can do as much work as I want to. ☐ I can only do my usual work, but no more. ☐ I can do most of my usual work, but no more. ☐ I cannot do my usual work. ☐ I can hardly do any work at all. ☐ I can't do any work at all.
Lifting ☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights, but it gives extra pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ☐ I can lift very light weights. ☐ I cannot lift or carry anything at all.	**Driving** ☐ I can drive my car without any neck pain. ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck. ☐ I cannot drive my car as long as I want because of moderate pain in my neck. ☐ I can hardly drive at all because of severe pain in my neck. ☐ I can't drive my car at all.
Reading ☐ I can read as much as I want to with no pain in my neck. ☐ I can read as much as I want to with slight pain in my neck. ☐ I can read as much as I want to with moderate pain in my neck. ☐ I can't read as much as I want because of moderate pain in my neck. ☐ I can hardly read at all, because of severe pain in my neck. ☐ I cannot read at all.	**Sleeping** ☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 1 hour sleepless). ☐ My sleep is mildly disturbed (1-2 hours sleepless). ☐ My sleep is moderately disturbed (2-3 hours sleepless). ☐ My sleep is greatly disturbed (3-5 hours sleepless). ☐ My sleep is completely disturbed (5-7 hours).
Headaches ☐ I have no headaches at all. ☐ I have slight headaches that come infrequently. ☐ I have moderate headaches that come infrequently. ☐ I have moderate headaches that come frequently. ☐ I have severe headaches that come frequently. ☐ I have headaches almost all the time.	**Recreation** ☐ I am able to engage in all of my recreational activities with no neck pain at all. ☐ I am able to engage in all of my recreational activities with some pain in my neck. ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck. ☐ I am able to engage in a few of my recreational activities because of pain in my neck. ☐ I can hardly do any recreation activities, because of pain in my neck. ☐ I can't do any recreation activities at all.

Patient Signature: _____ **Date:** _____

This questionnaire is designed to enable us to understand how much your **lower-back pain** has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is severe
- ☐ The pain is severe and does not vary much

Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it
- ☐ Washing and dressing increases the pain , and I find it necessary to change my way of doing it
- ☐ Because of the pain, I am unable to do some washing and dressing without help
- ☐ Because of the pain, I am unable to do any washing and dressing without help

Sleeping

- ☐ My sleep is never disturbed
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights, at the most.
- ☐ I cannot lift or carry anything at all.

Social Life

- ☐ My Social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pin has restricted my social life and I do not go our very often.
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of the pain

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but non of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Sitting

- ☐ I can sit in any chair as long as I like without pain
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than ten minutes
- ☐ Pain prevents me from sitting at all

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present
- ☐ My pain is neither getting better nor worse
- ☐ My pain is gradually worsening.
- ☐ My Pain is rapidly worsening.

Fill in the blank 1-5.

1 being the most important! 5 being the least important.

I Feel most loved when?

___ I Receive Words of Affirmation

___ I Receive Quality Time

___ I Receive a Gift

___ I Receive an Act of Service

___ I Receive Physical Touch

How can we apply this in our everyday lives? (FRAN)Friends, Relatives, Associates and Neighbors? Patients??

Matthew 22:36-40

"The 5 Love Languages" Gary Chapman

Patient name:_____

Date:_____