NEW PATIENT INFORMATION

PATIENT

First Name_____ M.I .___Last Name _____I.D._____
Sex _____ D.O.B._____ S.S. Number _____Driver License #_____
Address: _____E-mail_____
City _____State ____ Zip _____Home/Cell Phone_____

INSURED

First Name_____ M.I .___Last Name _____I.D._____
Sex _____ D.O.B._____ S.S. Number _____
Address: _____
City _____State ____ Zip _____ Phone _____

INSURANCE

Insurance Carrier _____
Address:_____
City _____State ____ Zip _____ Phone _____

EMPLOYER

Current Employer _____
Address: _____
City _____State ____ Zip _____ Phone _____

PATIENT INFORMATION

Date of Injury _____ Time of Injury _____ Date of 1st Tx _____
Is this Injury: □ Personal Injury □ Work Comp Injury □ Private Pay □ Group Ins. □ Medicare
□ Other

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance

IN ORDER TO CONTROL YOUR COST OF BILLINGS; WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT

If this account is assigned for collection and/or suite, collection costs and/or interest, and/or court costs will be added to the total amount due.
To the extend necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, to: _____
This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment
SIGNED _____ DATE _____

RESPONSIBLE PARTY* _____ DATE _____

DOCTOR FILLS OUT

STANDARD EXAMINATION

Name: _____ Date: _____ File # _____

VISUAL EVALUATION:

A: Physique:	1) Slim	2) Normal	3) Muscular	4) Overweight	5) Obese
B: Carriage&Gait	1) Normal	2) Slight Difficulty	3) Moderate Difficulty	4) Severe Difficulty	
C: Distress:	1) None Apparent	2) Mild	3) Moderate	4) Severe	
D: Antalgic Position	1) Head Tilt R L	2) Neck Rot. R L	3) Lat. Bending R L	4) Trunk Rot. R L	

VITAL SIGNS:

Height_____ Weight_____lbs. Pulse_____b.p.m. Resp._____/m B/P_____/_____

REFLEXES: _____ All Normal

DEEP	LEFT	RIGHT
Biceps	1 2 3 4	1 2 3 4
Triceps	1 2 3 4	1 2 3 4
Brachiordialis	1 2 3 4	1 2 3 4
Patellar	1 2 3 4	1 2 3 4
Achilles	1 2 3 4	1 2 3 4

DYNAMOMETER TEST:

	LEFT	RIGHT	
First Try:			lbs.
Second Try:			lbs.
Third Try:			lbs.

Patient is: L R Hand Dominant, Ambidextrous

Grip Set at: 1 2 3 4 5

CIRCUMFERENTIAL MEASUREMENTS:

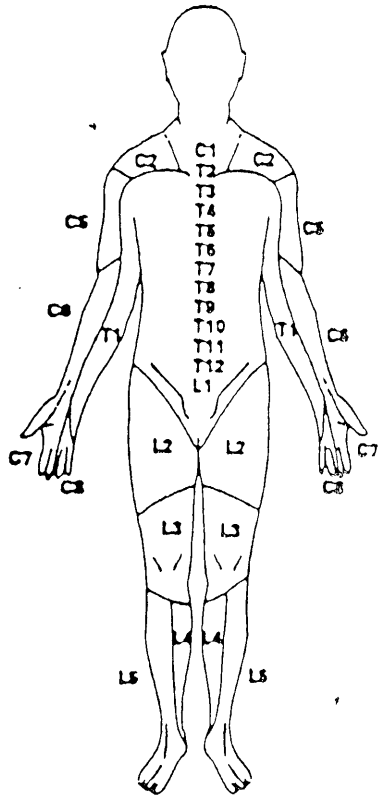
	LEFT	RIGHT	
Arm: 3" Above			in.
Forearm: 3" Below			in.
Thigh: 6" Above			in.
Calf: 6" Below			in.

NEUROLOGICAL TESTS:

	LEFT	RIGHT
Finger to Nose		
Toe Walk		
Heel Walk		
Rhomberg		

SUPERFICIAL SENSATION: _____ All Normal

	Lt.	Rt.
C1		
C2		
C3		
C4		
C5		
C6		
C7		
C8		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
S1		



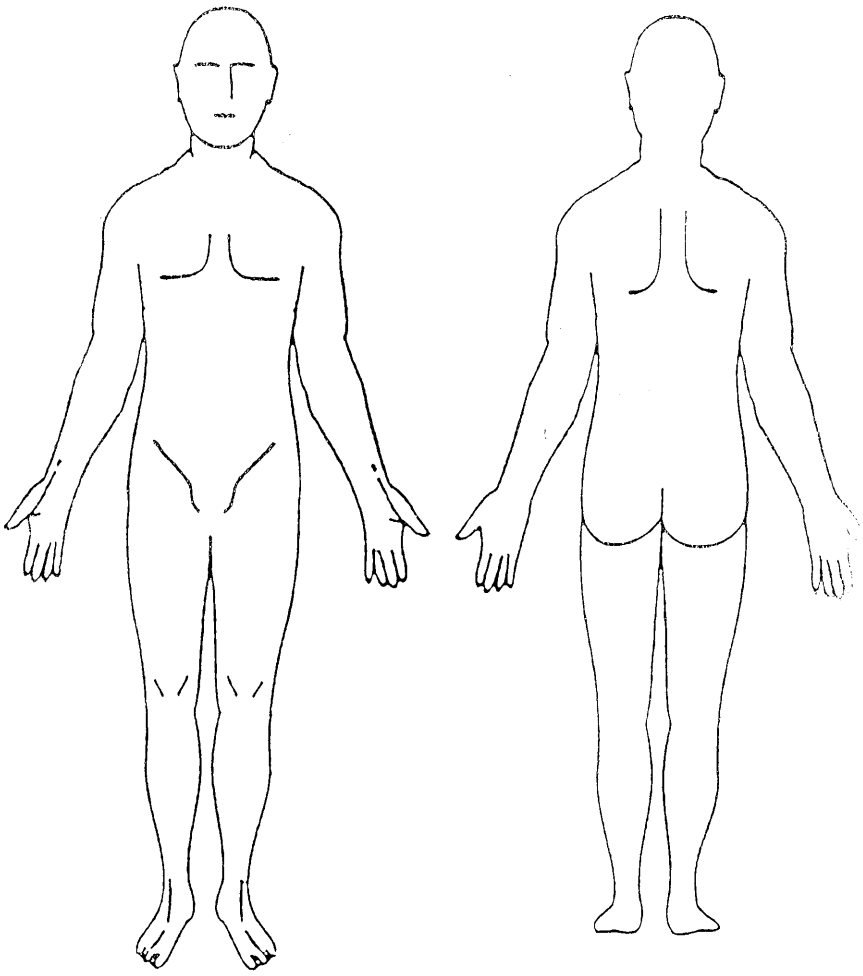
RANGES OF MOTION / ORTHOPEDIC TESTS:

Cervical ROM	Nor		Findings	Lumbar ROM	Nor		Findings
Flexion	50			Flexion	60		
Extension	60			Extension	25		
R-Lat. Flex	45			R-Lat. Flex	25		
L-Lat. Flex	45			L-Lat. Flex	25		
R-Rot	80			R-Rot			
L-Rot	80			L-Rot			

CERVICAL ORTHO	L	R	Findings	LUMBO PELVIC ORTHO	L	R	Findings
George's				Ely's			
Allen's				Kernig's			
Eden's				Patrick Faberé			
Wright's				S.L.R.			
Cerv. Com				Braggard's			
Cerv. Dist.				Dbl. S.L.R.			
Shldr. Dep.				Kemp's			
Soto Hall				Gaenslen's			
Valsalva				Burns Bench			
				Minor's Sign			

PALPATION:

	LEFT	RIGHT
Sub. Oc.		
C1		
C2		
C3		
C4		
C5		
C6		
C7		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
S1		
S2		
L-SI. Joint		
R-SI. Joint		
L-Sc.Notch		
R-Sc.Notch		



T- TENDERNESS, MS- MUSCLE SPASM,
E- EDEMA, F- FIXATION

COMMENTS:

NAME _____DATE_____

1. DATE OF ACCIDENT, TRAUMA OR ONSET OF SYMPTOMS: _____
2. PLACE OF ACCIDENT, TIME:
   _____
3. DID INJURY OCCURRED AT WORK? _____
4. DESCRIBE ACCIDENT: _____

   _____

5. WERE X-RAYS TAKEN? _____

6. DID YOU RECEIVE OTHER CARE? IF YES, WHERE AND BY WHOM? _____

_____

7. DESCRIBE YOUR COMPLAIN_____

_____

_____

8. PAIN _____

   a. ONSET _____

   b. PROVOCATIVE/PALLIATIVE (WHAT MAKES IT BETTER OR WORSE) _____

_____

   I. SPECIFIC POSITIONS _____

   II. MEDICATIONS (DO THEY HELP) _____

   c. QUALITY (ex. SHARP, CUTTING, BURNING, ACHING, BORING) _____

_____

   d. REGION (PIN-POINT; WELL LOCALIZED; NOT WELL LOCALIZED) _____

   e. DOES PAIN RADIATE? _____

   f. SEVERITY (SCALE FROM 1 TO 10, WITH 10 BEING THE WORST PAIN THE PATIENT HAS EVER EXPERIENCED – ex. CHILDBIRTH, FRACTURE, KIDNEY STONES, STROKE) _____

   _____

   g. TIMING (CONTINUOUS OR INTERMITTENT, DURATION) _____

9. DISABILITY: _____