



Spectrum Physical Therapy & Chiropractic, PLLC

CONFIDENTIAL PATIENT INFORMATION

In order to serve you properly, we need the following information *filled out COMPLETELY* please. Thank you.

PATIENT INFORMATION:

Patient Name: _____ Male Female Patient Social Security #: _____
 Address: _____ City _____ State _____ Zip _____
 Home Phone _____ Age _____ Birth Date _____ Marital Status: M S W D
 Work Phone _____ # Children _____ Spouse's Name _____
 Cell Phone _____
 Patient Occupation _____ Who may we thank for referring you? _____
 In case of emergency call _____ Phone _____

HEALTH INFORMATION

Present Complaint _____
 Other Complaints: _____
 How long have you had this condition? _____
 Have you had similar conditions in the past? _____
 Does this condition affect your work? Yes No
 Does this condition affect your family or social life? Yes No
 What aggravates this condition? _____

 Other Doctors seen for this condition _____
 Are you taking any medications? Please list. _____
 Are you allergic to any medications? Please list. _____
 What helps your symptoms? _____
 Have you had any surgery/ falls/ or accidents? Yes No
 If so, WHEN _____ Please describe: _____

 Is this condition due to:
 A work-related injury? Yes No An Automobile accident? Yes No
***If you answer YES to either of the above, please complete the other side of this form.**
 Primary Care Physician _____
 Date of last physical examination _____

	YES	NO
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory, Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Lung/Bronchial Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Any other health issues	<input type="checkbox"/>	<input type="checkbox"/>
Explain: _____		

INSURANCE INFORMATION (Please include ALL information for INSURED)

INSURANCE Company _____
 Insurance Address: _____
 Insured's Name: _____ Date of Birth: _____
 PATIENTS relation to INSURED Self Spouse Child Other
 Insured's EMPLOYER: _____
 Employer Address: _____

I understand and agree that health and accident insurance 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 I authorize payment directly to this office which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize the release of any medical or other information pertinent to my treatment and necessary to process any insurance claims.

Patient's Signature: _____ Date: _____
 Guardian / Parent Permission to treat minor: _____ Date: _____

JOB INJURY INFORMATION:

Date: _____ Time: _____ Location: _____

Description of accident: _____

Workmans' Compensation Case # _____

Insurance Company(Carrier): _____ Address: _____

Insurance Company/Carrier Case #: _____

Employer's Name: _____ Address: _____

Hospitalized? YES NO Name of Hospital: _____ X-Rays Taken? YES NO

Other Doctors seen: _____

Are you working now? YES NO - FULL PART-TIME

Time lost from work (if any): From _____ to _____

ACCIDENT INFORMATION:

Date: _____ Time: _____ Location: _____

How did accident occur? Auto Collision Other (explain) _____

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Front Right Side Left Side Auto was Parked

Did your car strike the other(s) involved? YES NO OR Did the other car strike your vehicle? YES NO Undetermined

As a result of the accident, were traffic citations issued to you? YES NO To the driver of the other vehicle? YES NO

List the extent of the injuries as you know them:

Did you require post-accident hospitalization? YES NO If so, how long: _____

Check symptoms you have noticed since the accident:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Have you lost any days of work? YES NO Dates: _____

Insurance Companies involved: _____

Your Insurance Company: _____ Your Claim Number: _____

Company of person responsible for injuries? _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES NO

Do you have an attorney that has advised you in this case? YES NO Attorney Name: _____