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Reactivation for Care at Health From Within Dubuque

Today's Date:_____ HRN:_____

PATIENT DEMOGRAPHICS

Name:_____ Birth Date: _____-_____-____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address:_____ Home Phone:_____ Mobile Phone:_____

Name & Number of Emergency Contact:_____ Relationship: _____

CHEIF COMPLAINT

Please identify the symptom (s) that brought you to this office:

Primarily: _____ Second:_____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

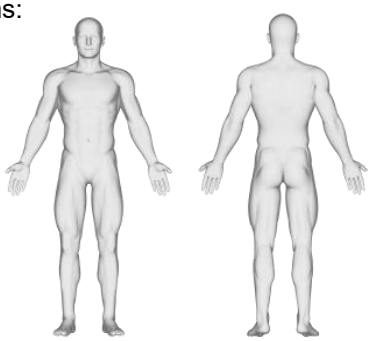
Primary or chief complaint is	: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is	: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____ When is the problem at its worst? ☐AM ☐PM ☐sleeping

How long does it last? ☐ It is constant ☐ on and off during the day ☐ It comes and goes throughout the week

***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



What relieves your symptoms?_____

What makes them feel worse?_____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

If Yes please explain _____

_____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

_____

_____

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Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ File#_____

Bending	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

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PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? _____

When was the last episode?_____

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment:_____,

_____

How long ago?___What were the results? ☐ Favorable ☐ Unfavorable

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

List Prescription & Non-Prescription drugs you take: _____

_____

_____

I hereby authorize payment to be made directly to Health From Within Dubuque for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Health From Within Dubuque for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___ JDD,DC 5/2011