WESTPORT PLAZA PAIN MANAGEMENT

MEDICAL INTAKE FORM

Date:_____ Last Name:_____ First Name:_____ MI:_____

Address:_____ City, State,Zip:_____

Employer:_____ Home Phone:_____ Work Phone:_____

Date of Birth:_____ Age:_____ Please Circle: Male or Female

Marital Status (please circle): Single Married Divorced Social Security Number:_____

Family Physician:_____Phone:_____E-Mail:_____

Please list medical concerns in order of importance (chief complaint #1):

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Medical History: Please check all that apply

- ❑ Arthritis
- ❑ Allergies (Hay fever)
- ❑ Asthma
- ❑ Alcoholism
- ❑ Blood Pressure
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Cholesterol-Elevated
- ❑ Circulatory Problems
- ❑ Colitis
- ❑ Dental Problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular Disease
- ❑ Emphysema
- ❑ Eyes, Ears, Nose Throat
- ❑ Environmental Sensitivities
- ❑ Fibromyalgia
- ❑ Gastroesophageal Reflux
- ❑ Glaucoma
- ❑ Gout Heart Disease
- ❑ Infection, Chronic
- ❑ Inflammatory Bowel Disease
- ❑ Irritable Bowel Syndrome
- ❑ Kidney or Bladder Disease
- ❑ Liver or Gallbladder Disease
- ❑ Migraine Headaches
- ❑ Neurological Problems
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Sexually Transmitted Disease
- ❑ Seasonal Affective Disorder
- ❑ Skin Problems
- ❑ Ulcer
- ❑ Urinary Tract Infections
- ❑ Varicose Veins
- ❑ Thyroid

Other_____

Operations:

- ❑ Appendectomy
- ❑ Prostate
- ❑ Cholecystectomy
- ❑ Tonsillectomy
- ❑ Hysterectomy
- ❑ _____

Allergies (please list):

- ❑ _____
- ❑ _____
- ❑ _____

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Please list any prescription medications, OTCs (over the counter medications), vitamins, minerals, supplements you are taking. Please list the amounts (i.e. 500 mg tablet 2x/day), when you take them (schedule) and why you are taking them. If you need more room, use bottom and/or back of page.

Prescription Medications

_____

_____

_____

_____

_____

_____

_____

Over-The-Counter Medications

_____

_____

_____

_____

_____

_____

_____

Vitamins/Minerals

_____

_____

_____

_____

_____

_____

_____

Other Supplements

_____

_____

_____

_____

_____

_____

_____

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Physical History: Please check all that apply.

Head:
- ❑ Headaches-one sided
- ❑ Headaches-involves back of neck
- ❑ Headaches-interfere with work
- ❑ Confusion, Brain Fog
- ❑ Dizziness, Unsteadiness
- ❑ Change in memory
- ❑ Blurred Vision
- ❑ Headaches-associated with light sensitivity
- ❑ Other_____

Eyes
- ❑ Itching
- ❑ Dryness
- ❑ Puffy under eyes
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Dark circles
- ❑ Sensitive to light
- ❑ Corrective Lenses
- ❑ Other_____

Ears:
- ❑ Hearing Loss
- ❑ Ringing/Roaring
- ❑ Pain
- ❑ Drainage
- ❑ Other_____

Nose:
- ❑ Itches
- ❑ Sneeze
- ❑ No sense of smell
- ❑ Runs
- ❑ Requires nose drops/spray
- ❑ Sinus infection
- ❑ Blood streaked mucous
- ❑ Other_____

Mouth and Throat
- ❑ Snore
- ❑ Bad breath
- ❑ Sore throats
- ❑ Wears dentures
- ❑ Hoarseness
- ❑ Grind teeth in sleep
- ❑ Neck glands swell
- ❑ Difficulty swallowing
- ❑ Other_____

Cardiac and Respiratory
- ❑ Wheeze
- ❑ Bronchitis
- ❑ Murmur
- ❑ Rapid heart beats
- ❑ Chest pains
- ❑ Productive cough
- ❑ Non-productive cough
- ❑ Skipped beats
- ❑ Cough up blood
- ❑ Ankle swelling
- ❑ Short of breath
- ❑ Night sweat

Gastrointestinal/Digestion
- ❑ Heartburn
- ❑ Indigestion
- ❑ Nausea/Vomiting
- ❑ Cramping
- ❑ Mucous in stool
- ❑ Bloating
- ❑ Stomach aches
- ❑ Anal pain
- ❑ Excess gas
- ❑ Rectal bleeding
- ❑ Diarrhea
- ❑ Constipated
- ❑ Belching frequently
- ❑ Blood in stool
- ❑ Other_____

Urinary and Genitalia:
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Pass blood
- ❑ Kidney stones
- ❑ Weak stream
- ❑ Genital herpes
- ❑ Yeast infection
- ❑ Difficulty starting urination
- ❑ Lumps, pain swelling testicles
- ❑ Unsatisfactory sexual relations
- ❑ Burning
- ❑ Present or previous cancer of the kidneys or urinary tract

Endocrine
- ❑ Fatigue
- ❑ Sleepiness in the afternoon
- ❑ Crave salt
- ❑ Heat intolerance
- ❑ Light headed upon standing
- ❑ Catch colds or infections easily
- ❑ Crave sugar
- ❑ Difficult getting out of bed
- ❑ Loss of libido
- ❑ Reaction time slowed down
- ❑ Deepening of voice
- ❑ Weight gain for no apparent reason
- ❑ Feel puffy or swollen all over your body
- ❑ Cold intolerance
- ❑ Feel cold, chilled-hands, feet all over for no apparent reason

Musculoskeletal
- ❑ Muscle weakness
- ❑ Other_____
- ❑ Decreased strength
- ❑ Morning stiffness
- ❑ Muscle cramps
- ❑ Muscle twitching
- ❑ Back pain
- ❑ Joint swelling, pain or stiffness
- ❑ Numbness/tingling of hands and feet
- ❑ Increased redness, warmth of joint
- ❑ Parts of the body feel tender, sore, sensitive to touch

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Skin:

- ❑ Eczema
- ❑ Easy bruising
- ❑ Brittle nails
- ❑ Hives
- ❑ Dry skin
- ❑ Other_____
- ❑ Rash
- ❑ Oily

Psychological:

- ❑ Often unhappy
- ❑ Difficulty falling asleep
- ❑ Misunderstood by others
- ❑ Unable to concentrate
- ❑ Use tranquilizers
- ❑ Considered a nervous person
- ❑ Easily flare in anger
- ❑ Frequently keyed up and jittery
- ❑ Am a workaholic
- ❑ Extremely shy or sensitive
- ❑ Difficulty staying awake
- ❑ Other_____

Social History: Please circle all that apply.

Married: Yes No If yes, how long_____

Children: Yes No If yes, how many_____

Occupation_____

Cigarettes: Yes No If yes, how much/day_____How many years_____

Cigars: Yes No If yes, how many/day_____or week_____

Chewing Tobacco: Yes No

Alcohol: Yes No If yes, drinks/day or week_____

Coffee: Yes No If yes, cups/day_____

PMI/FH:

Have you or any of your family members had any of the problems listed in this chart? Please indicate by checking the appropriate box.

	Father	Mother	Grandparents	Siblings	Children
Alcoholism					
Anemia					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Osteoporosis					
Mental Illness					
Thyroid Disorders					
Others-List					

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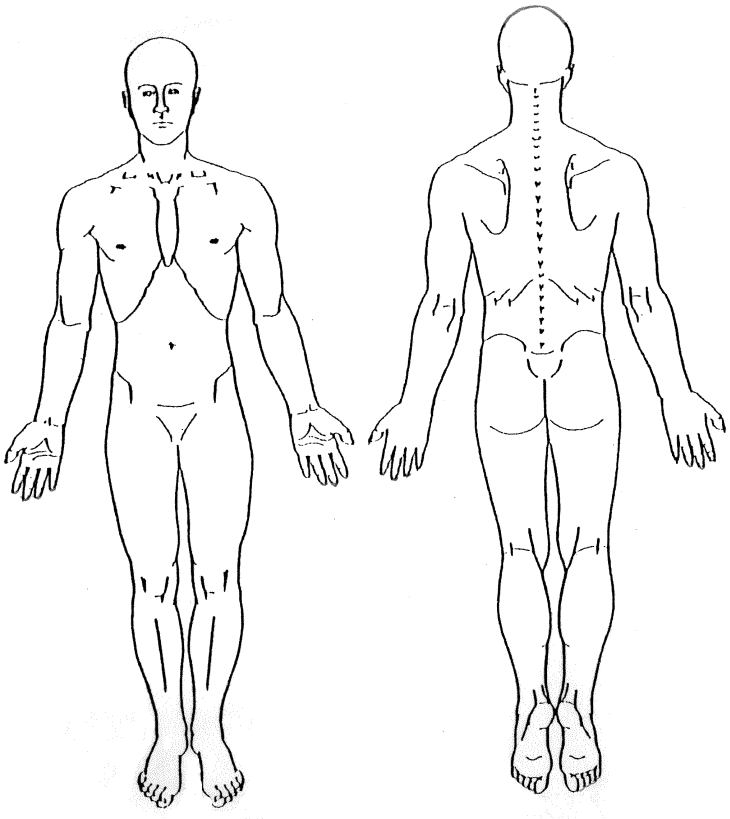
Please check the boxes below that reflect <u>any</u> symptoms that you may be experiencing or experienced in the past:

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back							
Mid Back							
Lower Back							
Shoulder							
Arm							
Forearm							
Wrist							
Hand							
Ribs							
Buttock							
Hip Thigh							
Leg							
Knee							
Ankle							
Foot							

Please circle/mark your area(s) of the signs and symptoms listed above.



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CONSENT TO TREAT

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

ACKNOWLEGEMENT OF FEES

I hereby acknowledge receipt of notice that Westport Plaza Pain Management does not file health insurance claims at this time. I understand that I am personally responsible for payment in full for the care that I receive at the time of service. I agree to the following fee schedule:

Initial Comprehensive Evaluation $200

Follow Up Visits $100

ATTENDENCE POLICY

It is **VERY** important that you are on time for each and every one of you appointments. Tardiness disrupts the flow of the office and other patient schedules. We strive to provide excellent medical care as well as efficient service for our patients. If you are more than 15 minutes late you will be charged $15 for every 15 minutes that you are late. If you have a circumstance that is going to cause you to be late please call the office as soon as possible to make other arrangements to avoid late charges. We understand that life can be unpredictable at times. We are happy to reschedule your appointment if necessary if you call in. Two no call no shows will result in your dismissal from our practice.

YOUR SIGNATURE HERE INDICATES THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE FEES AND POLICIES OF OUR PRACTICE. WE LOOK FORWARD TO HELPING YOU!

Patient Signature_____

Date:_____