SPORT & SPINE PERFORMANCE INSTITUTE
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Confidential Patient Data

PATIENT INFORMATION

Today's Date:___________

Fees, including deductibles and co-pays, are payable when services are rendered unless other arrangements are made. We are required to maintain original x-rays and records as property of this clinic.

Name_______________________________ **Date of birth** ______________

Address_____________________ **City**______________ **State**______ **Zip**__________

Home Phone ______________ **Work Phone** ______________ **Cell**______________

Emergency contact name and phone ______________________________

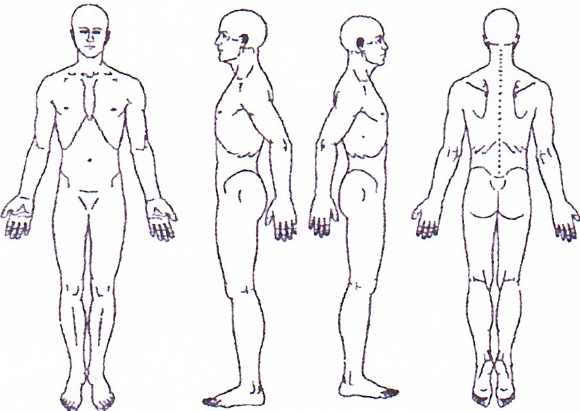
❑ **Male** ❑ **Female** **Marital Status** ______________ **Social Security#** ______________

Occupation____________________ **Employer:** ____________________

How did you hear about our clinic ______________

May we email you with occasional updates on our services? Email ______________________

Map your symptoms



PRESENT MAJOR COMPLAINTS:

Rate your pain (1-10 with 10 most severe)

Area	PAIN RATING	LOCATION (X)		FREQUENCY (X)	
	1-10	Right	Left	Constant	Intermittent
Headache					
Neck					
Shoulder					
Arm/hand					
Mid back					
Low back					
Hip					
Leg					
Knee/ankle					
Foot					

Symptoms are worse in: ❑Morning ❑Afternoon ❑Night ❑Other ______________

Is this a result of: ❑Job-related injury ❑Auto accident ❑Sport injury ❑Other ______________
❑Gradual onset ❑Unknown cause **Date occurred**: ______________

How long have symptoms persisted? ______________________________

Have you ever had this before: ❑NO ❑YES WHEN?______________________

Name and location of doctors consulted for **PRESENT CONDITION**(S):

______________________ ______________________________

______________________ ______________________________

Are you taking any medications? ❑NO ❑YES LIST:______________________

Are you pregnant? ❑NO ❑YES Date of last menstrual period ______________

Do you have children? ❑NO ❑YES Age(s):______________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑Bending	❑Reaching	❑Straining at stool	❑Coughing
❑Sitting	❑Turning head	❑Lifting	❑Sneezing
❑Walking	❑Lying down	❑Standing	❑Other ____________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑Bending	❑Stretching	❑Heat	❑Resting
❑Sitting	❑Turning head	❑Ice	❑Medication
❑Walking	❑Lying down	❑Standing	❑Other ____________

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑blurred vision	❑dizziness	❑insomnia	❑ringing in ears
❑buzzing in ears	❑diarrhea	❑light bothers eyes	❑shortness of breath
❑cold feet	❑face flushed	❑loss of balance	❑stiff neck
❑cold hands	❑fainting	❑loss of smell/taste	❑stomach upset
❑cold sweats	❑fatigue	❑low resistance to colds	
❑concentration loss /confusion	❑fever	❑muscle jerking	
❑constipation	❑head seems too heavy	❑numbness in fingers/toes	
❑depression /weeping spells	❑headaches	❑pins and needles in arms/legs	

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition______________________________ Date of Last Physical Exam__________

SURGICAL HISTORY:

1.______________________________ Date:____________

2.______________________________ Date:____________

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other ____________________ Date:____________

❑Job ❑Auto ❑Other ____________________ Date:____________

PAYMENT AGREEMENT: I understand that charges are due on the day of service; that insurance may not cover the full charges; that I am responsible for all balances due.

Signature (patient or legal guardian for minor) ______________________________

Please print name ______________________________ Date:____________