PARS HEALTH CLINIC

WELCOME

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____M.I._____Last Name:_____Preferred Name:_____

Address:_____City:_____State:_____Zip:_____

Birthdate:_____/_____/_____ Age_____Gender: □ Male □ Female □ Unspecified SSN:_____/_____/_____

Primary Phone:_____ Cell Phone:_____ Work Phone:_____

Home Email:_____ Work Email:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated Children? □ Yes □ No How Many:_____

Spouse's Name:_____

Preferred Language: □ English □ Spanish □ French □ Japanese □ Chinese □ German □ Other_____ □ I choose not to specify

Occupation:_____ Employer:_____

Emergency Contact: (Name, Relationship, Phone #)_____ Family

Physician Name:_____City:_____

Whom may we thank for referring you to our practice?

□ Patient_____ □ Physician_____ □ Internet □ Other_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with _____, and assign directly to Pars Health Clinic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

PATIENT CONDITION

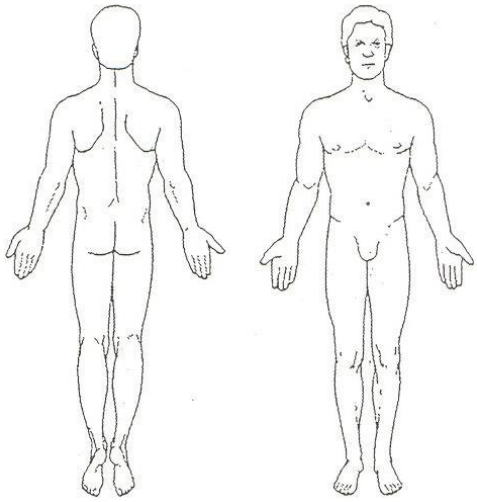
What is the reason for your visit today?□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes

What does your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other_____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain Moderate Pain Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping

□ During activities □ After activities □ Symptoms are constant and do not change □ Other:_____

Have you seen any other doctor for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____Diagnosis_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

NAME:_____ DATE:_____

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past.				Family History Mark ALL conditions that run in your family (Father,Mother,Sister,Brother)		Relationship:
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury Date of injury:	□	Cancer Type:	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II	□	Joint Pain (Circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

WOMEN ONLY:

Currently Pregnant? □ Yes □No Painful /Abnormal Menstrual Cycle? □ Yes □ No Menopause? □ Yes □ No

Miscarriage? □ Yes □ No Do you have children? □ Yes □ No If "Yes",type of birth? Circle Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had any X-ray or CT scan or MRI for your condition? □ Yes □ No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here □

Name of prescription medication	Dosage/Start date	4.	
1.		5.	
2.		6.	
3.		7.	

List any known allergies you have had to prescription medications

_____

SOCIAL HISTORY

Do you exercise? □ Yes □ No Times per week? Intensity? □ Light □ Moderate □ Strenuous Type?:
Do you currently smoke tobacco of any kind? □ Yes □ No
Do you drink alcohol? □ Yes □ No How many drinks per week? For how many years?
Do you drink caffeine? □ Yes □ No How many drinks per day?

Dated:_____ Dated:_____

_____ _____

Patient's Name (Please print) Doctor's Name (Please print)

X_____ _____

Signature of Patient, Parent or Legal Guardian (if a minor) Doctor's Signature

REV 8/18