Advanced Spinal Care & Rehabilitation
9515 Deereco Road, Suite 305
Timonium, MD 21093
410-252-0040

Patient Name_____ File # _____

# WELCOME

## Patient Information

Date_____
SS#_____

Patient Last Name_____

_____
First Name Middle Initial

Address_____
City _____State_____Zip_____
E-mail_____
Sex □ M □ F Age_____
Birthdate_____
□ Married □ Widowed □ Single □ Minor

□ Separated □Divorced □Partnered for __yrs
Occupation_____
Patient Employer/School_____
_____
Employer/School Address_____
_____
Employer/School Phone_____
Spouse's Name_____
Birthdate_____
SS#_____
Spouse's Employer_____

## Phone Numbers

Home Phone _____
Cell Phone_____

Best time and place
to reach you_____

In Case of Emergency, Contact:
Name_____
Relationship_____
Home Phone _____
Work Phone _____

## Accident Information

Is Condition due to an accident? □yes
□ no Date_____
Type of Accident □Auto □Work
□Home □Other
To Whom have you made a report of your accident? □ Auto Insurance
□ Employer □ Worker Comp
□ Other
Attorney Name (if applicable)
_____
_____

How did you find out about our office?_____
_____

## Patient Condition

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

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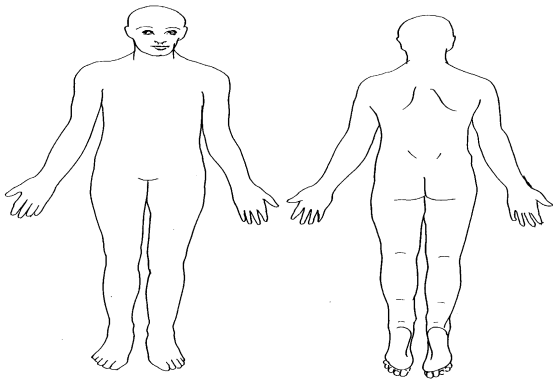
Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)
_____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning

□Tingling □Cramps □Stiffness □Swelling □Other _____

How often do you have this pain?_____
Is it constant or does it come and go?_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Activities or movements that are painful to perform □Sitting □Standing □Walking □Bending □Lying Down

## ***Health History***

What treatment have you already received for your condition? □Medications □Surgery □Physical Therapy □Chiropractic Services □None
□Other_____

Name and address of other doctor(s) who have treated you for your condition_____
_____
_____
_____
_____

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Date of Last: Physical Exam_____Spinal X-Ray_____ Blood Test_____
Spinal Exam_____Chest X-Ray_____ Urine Test_____
Dental X-Ray_____MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | □Yes □No | Chicken Pox | □Yes □No | Liver Disease | □Yes □No | Rheumatoid Arthritis | □Yes □No |
| Alcoholism | □Yes □No | Diabetes | □Yes □No | Measles | □Yes □No | Rheumatic Fever | □Yes □No |
| Allergy Shots | □Yes □No | Emphysema | □Yes □No | Migraine Headaches | □Yes □No | Scarlet Fever | □Yes □No |
| Anemia | □Yes □No | Epilepsy | □Yes □No | Miscarriage | □Yes □No | Stroke | □Yes □No |
| Anorexia | □Yes □No | Fever | □Yes □No | Fractures | □Yes □No | Mononucleosis | □Yes □No |
| Suicide Attemp | □Yes □No | Appendicitis | □Yes □No | Glaucoma | □Yes □No | Multiple Sclerosis | □Yes □No |
| Thyroid Proble | □Yes □No | Arthritis | □Yes □No | Goiter | □Yes □No | Mumps | □Yes □No |
| Tonsillitis | □Yes □No | Asthma | □Yes □No | Gonorrhea | □Yes □No | Osteoporosis | □Yes □No |
| Tuberculosis | □Yes □No | Bleeding Disorders | □Yes □No | Gout | □Yes □No | Pacemaker | □Yes □No |
| Tumors, Growths | □Yes □No | Breast Lump | □Yes □No | Heart Disease | □Yes □No | Parkinson's Disease | □Yes □No |
| Typhoid Fever | □Yes □No | Bronchitis | □Yes □No | Hepatitis | □Yes □No | Pinched Nerve | □Yes □No |
| Ulcers | □Yes □No | Bulimia | □Yes □No | Hernia | □Yes □No | Pneumonia | □Yes □No |
| Vaginal Infections | □Yes □No | Cancer | □Yes □No | Herniated Disk | □Yes □No | Polio | □Yes □No |
| Venereal Disease | □Yes □No | Cataracts | □Yes □No | Herpes | □Yes □No | Prostate Problem | □Yes □No |
| Whooping Cough | □Yes □No | Chemical Dependency | □Yes □No | High Cholesterol | □Yes □No | Prosthesis | □Yes □No |
| Kidney Disease | □Yes □No | Psychiatric Care | □Yes □No | Other_____ _____ | | | |

**EXERCISE**
□ None
□ Moderate
□ Daily
□ Heavy

**WORK ACTIVITY**
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

**HABITS**
□ Smoking Packs/Day_____
□ Alcohol Drinks/Week_____
□ Coffee/Caffeine Cups/Day_____
□ High Stress Level Reason_____

For Women:
Are you pregnant? □ Yes □ No Due Date_____

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**Injuries/Surgeries you have had** **Description** **Date**

Falls_____
_____
_____

Accidents_____

_____

Head Injuries_____

Broken Bones_____

Dislocations_____

Surgeries_____
_____

**Family Health History:**
_____

_____

_____

_____

| **Medications** | **Allergies** | **Vitamins/Herbs/Minerals** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Primary Care Physician Name _____**

**Primary Care Physician Phone_____**
**Pharmacy Name _____**
**Pharmacy Phone_____**