

PATIENT DATA SHEET

PERSONAL INFORMATION

DATE: _____

PATIENT NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____) _____ WORK / CELL PHONE: (____) _____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

MARITAL STATUS: S M D W EMPLOYER: _____

OCCUPATION: _____ REFERRED BY: _____

EMERGENCY CONTACT NAME : _____ RELATIONSHIP: _____

PHONE #: _____

EMAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION / NAME OF INSURED

NAME: _____
First Middle Initial Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____) _____ ALTERNATE PHONE: (____) _____

SOC SEC #: _____ DATE OF BIRTH: _____ GENDER: _____

EMPLOYER: _____ OCCUPATION: _____

CONSENT TO TREAT

I hereby authorize consent for _____ (clinic/doctor), to provide medical care and treatment.

PRINT: _____ SIGN: _____ DATE: _____
Patient Patient

PRINT: _____ SIGN: _____ DATE: _____
Patient or Legal Guardian Patient or Legal Guardian

AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorized and request my insurance company to pay directly to _____ (clinic), insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents.

PRINT: _____ SIGN: _____ DATE: _____
Patient Patient

PRINT: _____ SIGN: _____ DATE: _____
Patient or Legal Guardian Patient or Legal Guardian

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

	0	1	2	3	4
Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					
Other: _____					
Totals					

COMMENTS: _____

SCORE: _____

Pain Drawing

Name: _____

Date: _____

Tell us where you hurt.

Please read carefully:

Mark the areas on your body where you feel you pain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>

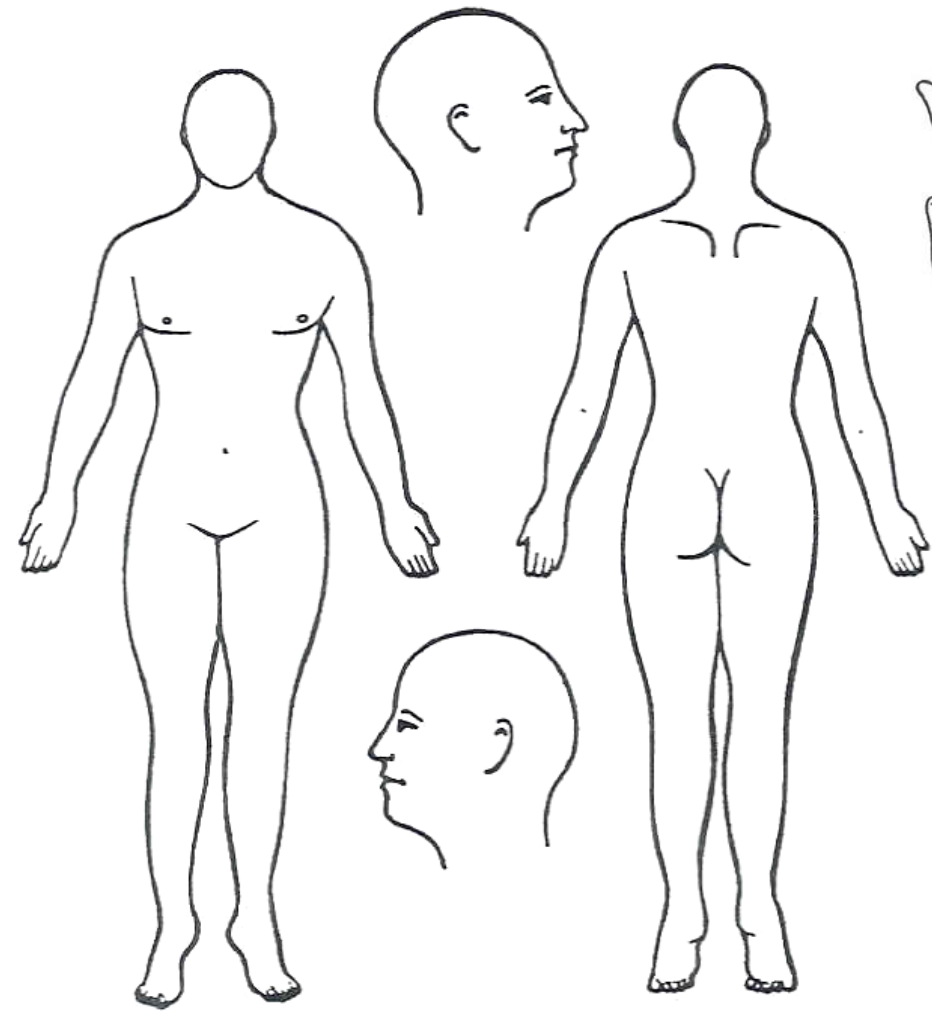
Numbness =====

Pins and Needles ○○○○

Burning x x x x

Stabbing /////

Throbbing ~ ~ ~ ~



Severity of Pain

List the region of pain.
Circle the severity number.
1=least pain, 10=greatest pain

- ex: _____ NECK _____
 0 1 2 3 4 5 6 7 8 9 10
1. _____
 0 1 2 3 4 5 6 7 8 9 10
2. _____
 0 1 2 3 4 5 6 7 8 9 10
3. _____
 0 1 2 3 4 5 6 7 8 9 10
4. _____
 0 1 2 3 4 5 6 7 8 9 10
5. _____
 0 1 2 3 4 5 6 7 8 9 10