



Multiprofessional and
Comprehensive Approach to
Pain Relief and Rehabilitation

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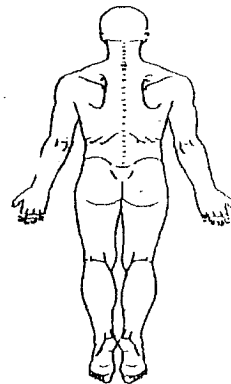
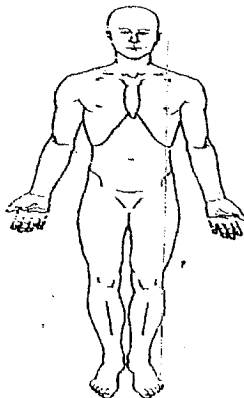
CONFIDENTIAL PATIENT INFORMATION

Name: _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____ Cell Phone # / Pager # _____
Today' Date ____ / ____ / ____ Date of birth ____ / ____ / ____ Age ____ Sex: Male Female
Marital Status: M S D W, # of Children _____ Ages: _____ E-Mail address: _____
Family Physician's Name _____ Phone # _____ Fax # _____
Address _____ Date of last exam ____ / ____ / ____
What tests were done and what were the results? _____
Have you seen any other physicians for your condition? Yes No _____
Employer _____ Occupation _____
Employers address _____ City _____ State _____ Zip _____
What type of work do you do? _____ Do you work with computers or phone routinely? _____
How often do you exercise? _____ What type of exercise? _____
Spouse's name: _____ SS# _____
Home phone # _____ Work # _____ Date of birth ____ / ____ / ____
Spouse's employer and address _____

CURRENT HEALTH CONDITIONS

Main areas of complaint/treatment request: _____
How do your complaints affect your daily life & activities? _____
How long & how frequent you experience these symptoms? _____ What started your symptoms? _____
What aggravates you symptoms? _____
Is there anything that makes your symptoms less intense? _____
Is this condition: Job related Auto accident Home injury Other: _____ Date of accident: ____ / ____ / ____
Has your symptoms been getting worse: Yes No Your height _____ Your weight _____

Please mark the area of your complaint on the diagrams



Do you experience any of the following? Check only the ones that you now have or had in the past

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Low back pain	<input type="checkbox"/>	<input type="checkbox"/> Hip or leg pain	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Neck pain	<input type="checkbox"/>	<input type="checkbox"/> Knee pain	<input type="checkbox"/>	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> Ankle pain	<input type="checkbox"/>	<input type="checkbox"/> High level of stress
<input type="checkbox"/>	<input type="checkbox"/> Disc problems	<input type="checkbox"/>	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Sciatica	<input type="checkbox"/>	<input type="checkbox"/> Strange Sensation/Loss of feeling /	<input type="checkbox"/>	<input type="checkbox"/> Weakness
<input type="checkbox"/>	<input type="checkbox"/> Shoulder pain		Pins and needles/Numbness WHERE? _____	<input type="checkbox"/>	<input type="checkbox"/> Anxiety
<input type="checkbox"/>	<input type="checkbox"/> Arm pain			<input type="checkbox"/>	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/>	<input type="checkbox"/> Elbow pain	<input type="checkbox"/>	<input type="checkbox"/> Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Hand pain	<input type="checkbox"/>	<input type="checkbox"/> Painful joints/Arthritis	<input type="checkbox"/>	<input type="checkbox"/> TMJ

Have you ever had or experienced a significant or persisting level of the following symptoms or conditions?

<input type="checkbox"/> Chest pain/Tightness	<input type="checkbox"/> Neurological problems	<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Over the heart pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Chills	<input type="checkbox"/> Nausea
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Family history of heart disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver/Gall bladder problems
<input type="checkbox"/> Cardiovascular/Heart problems	<input type="checkbox"/> Vision/Eye problems	<input type="checkbox"/> Excessive thirst/hunger
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sore throat/mouth	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Nose problems	<input type="checkbox"/> Sudden weight loss/gain
<input type="checkbox"/> Pulmonary/Lung problems	<input type="checkbox"/> Dental/Gum problems	<input type="checkbox"/> High blood sugar (Diabetes)
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Ear problems	<input type="checkbox"/> Gynecological problems
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Skin changes	<input type="checkbox"/> Breast problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Menstrual problems
<input type="checkbox"/> TMJ	<input type="checkbox"/> Blood problems/Varicose veins	<input type="checkbox"/> Urinary/Bladder problems

GENERAL HEALTH INFORMATION

Are you currently taking any medication? Yes No If yes, please explain: _____

Do you have any allergies (food, medication)? Yes No If yes, please explain: _____

Have you ever diagnosed with any heart condition? Yes No If yes, please explain: _____

Do you have a pacemaker or metal in your body? Yes No If yes, what: _____

Have you had any surgeries or hospitalization? Yes No If yes, when: _____

Do you have a history of fainting? Yes No

Do you smoke? Yes No If yes, how much: _____

Do you drink alcoholic or caffeine containing beverages? Yes No If yes, what & how much: _____

Is there any condition, which runs in you family? Yes No If yes, what: _____

FEMALE ONLY:

Is there any possibility that you might be pregnant? Yes No

Are you taking birth control pills? Yes No

Name of your Gynecologist: _____ Date of last Gynecological exam? _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Phone # _____

Address _____ Policy # _____

Name of Insured _____ SS# _____

Do you have also a secondary coverage? _____ Phone # _____

I understand and agree that my health insurance policies are an arrangement between my insurance carriers and myself, however I understand that I am ultimately responsible for my entire bill. I also give permission to all Spine and Sports Medicine of Ho Ho Kus, L.L.C. (SSMH) staff members to contact me and leave a message with a live person or on an answering machine, any pertaining information in reference to my care, insurance co-payments, collections, and upcoming events. I authorize this office to collect payment from my insurance company directly for services rendered. I also understand and give full power of attorney and authority to SSMH, L.L.C. staff to fill out and sign on my behalf any necessary paper work and reports utilizing given information and/or forms to assist me in making collections, requesting visits from my insurance company And/or obtaining referrals/prescriptions for care. I voluntarily ask and authorize SSMH, L.L.C. to receive payments directly from my insurance carrier and note on my bills SSMH, L.L.C.'s address as guarantor's address and my residence address since I do not want to receive insurance checks at home and I would rather them come to SSMH, L.L.C. directly. In the event that my insurance carrier sends payment directly to SSMH, L.L.C. for services which was rendered to me, I give full power of attorney to SSMH, L.L.C to sign the back of the checks payable to me or the insured and deposit the check into the SSM, L.L.C. account. I authorize my insurance company or my attorney to reimburse SSMH, L.L.C. directly for services rendered. SSMH, L.L.C. will credit my account upon receipt. I also understand that in the event I or my attorney receive payments directly for services rendered and billed by SSMH, L.L.C., I or my attorney must forward payments in full within 36 hours of receipt to SSMH, L.L.C. I clearly understand and agree that there are no guaranteed results for care and/or treatment. I understand that if I am here today due to a special promotion or offer my reduced fee services excluded any comprehensive consultations, spinal x-rays or any other therapies except the ones mentioned in the offer and I will be fully responsible to pay for excluded services. I voluntarily consent to receive all services, which deemed medically necessary by SSMH, L.L.C. clinical staff and agree to be charged for all services. I further understand and accept to be responsible for 1.5% interest per month added on my past balance to my account if it is delinquent for 60 days in addition to any collection and attorney fees which I incur for SSMH, L.L.C for collection of my dept. I authorize SSMH, L.L.C. to send initial and updated reports to any doctors that I have listed in my initial confidential form. I authorize SSMH, L.L.C. to request or send any or al of my medical records, x-rays and/or information from or to any health care professional that I have listed in my initial confidential questionnaire and/or insurance carrier that may require information/records that may be germane to my case.

Signature: _____ Date: _____