Confidential Patient Information

Patient ID #:_____

First Name: _____ Middle Initial: _____ Last Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth:_____ Age:_____ Number of Children_____

SSN:_____ -_____-_____

Spouse's Name:_____ Marital Status: Married Single Widow Divorced

Occupation:_____ Dominant Hand: ___Right ___Left ___Both

Email:_____@_____._____

Home #: ( ) _____-_____Work#: ( )_____-_____Cell# ( )_____-_____

Emergency Contact: _____Contact # ( )_____-_____

Auto Insurance Company: _____**Date of Injury**:_____-_____-_____

Auto Insurance Address:_____

Policy Holder (If different than patient):_____

Claim Number/Policy ID: _____

Did you receive treatment anywhere? If so, where? _____

Attorney Information: _____

Attorney Address: _____

Attorney Contact #: ( ) _____-_____

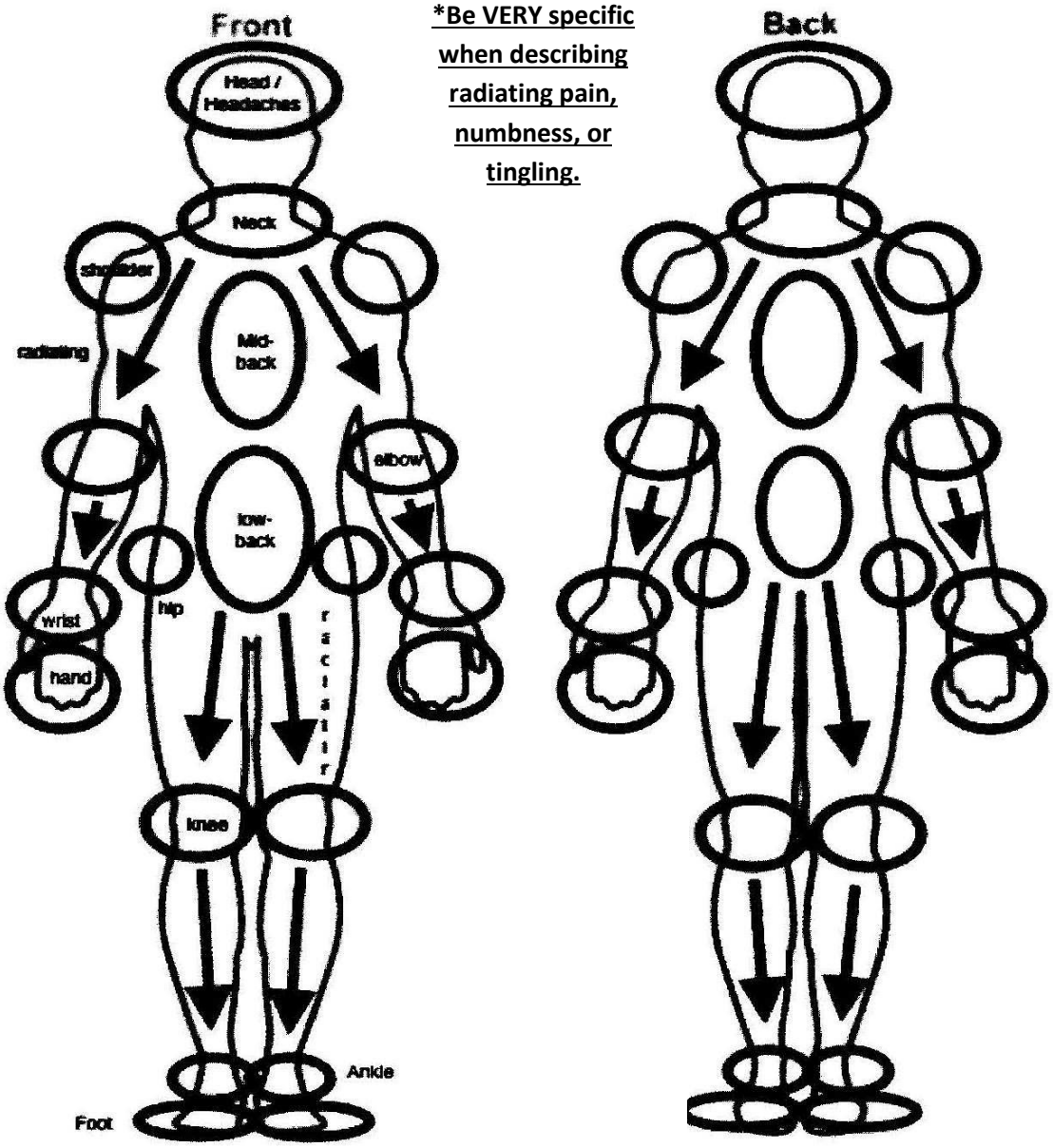
Description of Symptoms –

(Check off or Circle your symptoms in the sections below.)

○ Headaches		**Left**	**Right**	**Both Sides**	**Type of Pain:**	**List ALL that**
		Front of Head				**Apply from**
		Top of Head				**List below**
		Back of Head				
○ Jaw		Left	Right	Both Sides		
○ Eye		Left	Right	Both Sides		
○ Neck		Left	Right	Both Sides		
○ Upper Back		Left	Right	Both Sides		
○ Mid Back		Left	Right	Both Sides		
○ Low Back		Left	Right	Both Sides		
○ Chest		Left	Right	Both Sides		
○ Abdomen		Left	Right	Both Sides		
○ Ribs		Left	Right	Both Sides		
○ Buttocks		Left	Right	Both Sides		
○ Shoulder		Left	Right	Both Sides		
○ Upper Arm		Left	Right	Both Sides		
○ Forearm		Left	Right	Both Sides		
○ Hand		Left	Right	Both Sides		
○ Knee		Left	Right	Both Sides		
○ Hip		Left	Right	Both Sides		
○ Leg		Left	Right	Both Sides		
○ Foot		Left	Right	Both Sides		
TYPES OF PAIN:		Dull	Sharp	Aching	Cutting	Shocking
		Throbbing	Burning	Numbing	Tingling	Cramping
		Spasm	Stinging	Shooting	Pounding	Constricting
Other types of pain:		_____	_____	_____	_____	

Patient Name:_____ ID#_____ Date:_____

Right **Left** **Left** **Right**



***Be VERY specific when describing radiating pain, numbness, or tingling.**

Right **Left** **Left** **Right**

***PLEASE SPECIFY IN CIRCLED AREAS PAIN LEVEL FROM 1-10 WITH 10 BEING THE HIGHEST.**

Name: _____ Date: _____