

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.

SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?

IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name _____ Middle _____ Last _____

Gender Male Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number _____ - _____ - _____ E-mail Address _____

Birthdate _____ Age _____ Marital Status S M W D

Job Title _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Social Security Number _____ - _____ - _____

Person responsible for this account _____

Name of person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children—Names & Ages _____

In case of emergency, whom should we contact? _____

Phone _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

IS THIS WORKMAN'S COMPENSATION? _____ IS THIS PERSONAL INJURY? _____

I give HealthSource permission to contact me via mail, electronic e-mail, electronic text messaging, or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me.

I understand that I am not required to sign this agreement to receive treatment. I can choose to opt-out of this agreement at any time.

Patient Signature: _____ Phone: _____ Cell Phone w/text Date: _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

(Office use only)

Account Number

Date

NAME: _____ DATE: ____/____/____ Account#: _____

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

What caused the onset? _____

Date of onset? ____/____/____

TIMING AND DURATION

How often do you experience this pain? _____ Constant _____ Frequent _____ Intermittent _____ Occasional

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None	1 = Minimal	2 = Very Mild	3 = Mild	4 = Mild to Moderate	5 = Moderate
6 = Moderate to Severe	7 = Mildly Severe, Restricts Some Activity	8 = Severe, Limits Most Activity	9 = Very Severe	10 = Excruciating	

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the least intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the most intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____ Inflexibility _____ Stiffness _____ Spasms _____ Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

- | | | | | |
|---------------|---------------|----------------|---------------------|---------------|
| ____ Deadness | ____ Prickly | ____ Numb | ____ Crawling | ____ Tingling |
| ____ Stabbing | ____ Hurting | ____ Pulsating | ____ Pins & Needles | ____ Pounding |
| ____ Burning | ____ Shooting | ____ Throbbing | ____ Stinging | |
| ____ Dull | ____ Sharp | ____ Aching | ____ Excruciating | |

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

MODIFYING FACTORS

What aggravates the pain/symptom?

- | | | | | |
|-------------------------|----------------------|----------------------|------------------------|----------------------------|
| ____ Flashing lights | ____ Sneezing | ____ Lifting | ____ Exercising | ____ Looking up/down |
| ____ Coughing | ____ Sitting | ____ Stooping | ____ Looking side/side | ____ Anger |
| ____ Standing | ____ Depression | ____ Stress | ____ Driving | ____ Walking |
| ____ Getting out of bed | ____ Pushing | ____ Emotional upset | ____ Pulling | ____ Repetitive movement |
| ____ Carrying | ____ Straining at BM | ____ Climbing stairs | ____ Walking uphill | ____ Getting in/out of car |

Other: _____

What relieves this pain/symptom?

- | | | | | |
|------------------|-------------------|---------------|------------------------|----------------------|
| ____ Resting | ____ Sleeping | ____ Lifting | ____ Exercising | ____ Looking up/down |
| ____ Shower | ____ Advil | ____ Stooping | ____ Looking side/side | ____ Anger |
| ____ Mineral Ice | ____ Other: _____ | | | |

Over the past weeks/months this complaint is: _____ Improving _____ Getting worse _____ About the same

Patient history was obtained from: _____ Patient _____ Father _____ Mother _____ Son _____ Daughter

Have you seen anyone for this condition? _____ YES _____ NO WHOM? _____

Do you have a pacemaker? _____ YES _____ NO	Are you Pregnant? _____ YES _____ NO
	Do you think you may be pregnant? _____ YES _____ NO

Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the least intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the most intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ___ Inflexibility ___ Stiffness ___ Spasms ___ Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

- | | | | | |
|--------------|--------------|---------------|--------------------|--------------|
| ___ Deadness | ___ Prickly | ___ Numb | ___ Crawling | ___ Tingling |
| ___ Stabbing | ___ Hurting | ___ Pulsating | ___ Pins & Needles | ___ Pounding |
| ___ Burning | ___ Shooting | ___ Throbbing | ___ Stinging | |
| ___ Dull | ___ Sharp | ___ Aching | ___ Excruciating | |

Over the past weeks/months this complaint is: ___ Improving ___ Getting worse ___ About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the least intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the most intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ___ Inflexibility ___ Stiffness ___ Spasms ___ Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

- | | | | | |
|--------------|--------------|---------------|--------------------|--------------|
| ___ Deadness | ___ Prickly | ___ Numb | ___ Crawling | ___ Tingling |
| ___ Stabbing | ___ Hurting | ___ Pulsating | ___ Pins & Needles | ___ Pounding |
| ___ Burning | ___ Shooting | ___ Throbbing | ___ Stinging | |
| ___ Dull | ___ Sharp | ___ Aching | ___ Excruciating | |

Over the past weeks/months this complaint is: ___ Improving ___ Getting worse ___ About the same

FOURTH COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the least intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What is the most intense the symptom has been on a scale of 0 to 10?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ___ Inflexibility ___ Stiffness ___ Spasms ___ Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

- | | | | | |
|--------------|--------------|---------------|--------------------|--------------|
| ___ Deadness | ___ Prickly | ___ Numb | ___ Crawling | ___ Tingling |
| ___ Stabbing | ___ Hurting | ___ Pulsating | ___ Pins & Needles | ___ Pounding |
| ___ Burning | ___ Shooting | ___ Throbbing | ___ Stinging | |
| ___ Dull | ___ Sharp | ___ Aching | ___ Excruciating | |

Over the past weeks/months this complaint is: ___ Improving ___ Getting worse ___ About the same

Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:



P	N		PN	P	N		PN	P	N		PN	P	N		PN
		Weakness				Muscle Pain				Seizures				Animal Dander	
		Fatigue				Muscle Weakness				Vertigo				Latex	
		Fever				Muscle Cramps				Dizziness				Food Allergies	
		Chills				Joint Stiffness				Tremors				Penicillin	
		Night Sweats				Joint Tenderness				Loss of Sensation				Pollen	
		Fainting				Spinal Curvature				Loss of Coordination				Second Hand Smoke	
		Nervousness				Back Pain				Weak Grip				Grasses	
		Concentration Loss				Hot Joints				Paralysis				Sulfa Drugs	
		Dizzy Spells				Joint Swelling				Difficulty of Speech				Dairy Products	
		Irritability				Stiff Neck				Tingling				Perfumes	
		Depression				Soreness				Numbness				Hay	
		Memory Loss				Lumps									
		Loss of Sleep				Masses									
		Headache													
		Apprehension													

Check additional form for additional Review of Systems
 OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE



____ Previous Review of Systems reviewed. Date of previous Review of Systems was: ____/____/____

System Reviewed

____ Constitutional ____ Musculoskeletal ____ Neurological ____ Allergic

____ Other, please note: _____

____ No change in systems review

____ Previous Past History reviewed and updated. Date of Past History update: ____/____/____



____ No change in Past History ____ See old Past History for changes

____ Previous Social History reviewed and updated. Date of Social History updated: ____/____/____

____ No change in Social History ____ See old Social History for changes



____ Previous Family History reviewed and updated. Date of Family History updated: ____/____/____

____ No change in Family History ____ See old Family History for changes



Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:



P	N	Past Problem	When and Explanation of Condition
		Cancer	
		Balance Problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		Other	

SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR
Tonsils				WOMEN			
Colon				Breast			
Hernia				Uterus			
Appendix				Ovaries			
Gall Bladder				MEN			
Stomach				Prostate			
Heart				Other			
Kidney							
Other							
What other major injuries have you had? Date				Have you ever taken:			
				Insulin			
				Cortisone			
				Thyroid Medicine			
				Male/Female Hormones			
What medications are you currently taking? Date				Blood Pressure			
				Tranquilizers/Sedatives			
				Birth Control			

Hospitalizations:

Doctor Signature: _____

Patient Signature: _____

NAME:

DATE:

/ /

Account#:

Marital Status Married Divorced Single Separated Widowed

Number of Children: _____

Frequency of Exercise Never Rarely Occasionally Moderately Regularly

Intensity of Exercise Low Level Medium Level High Level Competition Level

Sufficient Rest Never Rarely Occasionally Moderately

Hours of Sleep _____ 10 or more hours

Well balanced diet Never Rarely Occasionally Moderately

Do you smoke? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 packs/day

Do you drink caffeinated beverages?
 No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 drinks/day

Do you drink alcoholic beverages?
 No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 drinks/day

Have you ever used street drugs? Yes No

Hobbies: _____

How did you hear about us? _____

If from advertisement:

1) Newspaper Insert? _____ Which Newspaper? _____

2) Free Report? _____

3) Infomercial? _____

4) Decompression? _____

5) Other _____

Billboard? _____

Yellow Pages? _____

Website? _____

Family or Friend? _____

Monthly Newsletter? _____

Doctor Signature: _____

Patient Signature: _____