Patient Information

Your Name ______________________________ Today's Date ______________

Driver's License #/State ______________________ Social Security Number: ____________

Date of Birth: ______________ Age: ______ Gender: ☐ Male ☐ Female

Street Address: ____

City/State/Zip: ____

Email: ____

Physical Address Same as Mailing? ☐ Yes ☐ No If not, please list mailing address: ______________

____

____

Preferred Phone: ______________________ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: ______________________ ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: ______________________________________

Phone: ______________________ Relationship: ______________________

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language: ☐ English ☐ Spanish ☐ Other______________________________

Referral

Who is your Primary Care Provider? ______________________________________

Were you referred to our clinic by another physician? If so, whom? ______________________

If not, how did you hear about us? ☐ TV ☐ Radio ☐ Insurance Company ☐ Family ☐ Friend ☐ PCP

☐ Facebook ☐ Twitter ☐ YouTube ☐Other Website______________

Social Status

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widowed ☐ Other ______________________

Preferred Pharmacy Information

Pharmacy Name: ______________________ Phone Number: ______________

Street Address: ______________________ City/State/Zip: ______________

Do you have a prescription Drug ID card?: ☐ Yes ☐ No Member ID #: ______________

RX Bin #: ______________ RX Group #: ______________

City/State/Zip: ______________________

Email: ______________________

Primary Insurance Plan

Payer (e.g. BC/BS): ______________________ Plan: ______________

Policy/I.D. Number: ______________ Group Number: ______________

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Policy Holder Name: ______________ Policy Holder Gender: ☐ Male ☐ Female

Date of Birth: ______________ Social Security Number: ______________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): ______________________ Plan: ______________

Policy/I.D. Number: ______________ Group Number: ______________

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Policy Holder Name: ______________ Policy Holder Gender: ☐ Male ☐ Female

Date of Birth: ______________ Social Security Number: ______________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation Claim.

Workers Comp Company: ______________________

Agent Name: ______________________ State of Injury: ______________

Phone number: ______________ Fax Number: ______________

Claim Number: ______________ Date of initial injury: ______________

Injury Claim

Is your paint the result of a Motor Vehicle Accident or Personal Injury? ☐ Yes ☐ No

I certify that the above information is accurate, complete and true. I give my consent to Omega Rehabilitation & Spine to re-trieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: ______________________ Date: ______________

Patient Name: ______________________________ Date of birth:______________

Complete this box only if you were involved in an auto accident.

Were you wearing a seat belt? ☐ Yes ☐ No
Were you the passenger? ☐ Yes ☐ No
Were you the driver ? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? ______________
Briefly describe the accident:
____
How much damage was done to your vehicle? ______________
How long after the incident did the pain occur? ______________
When did you first seek medical attention? _____/_____/________
Did you experience pain in the same location previous to this accident? ☐ Yes ☐ No
If yes, explain: ______________________________
____

Complete this box only if you were involved in a work injury.

Describe injury: ______________________________
How long after the incident did the pain occur? ______________________________
When did you first seek medical attention? _____/_____/________
Did you experience pain in the same location previous to this accident? ☐ Yes ☐ No
If yes, explain: ______________________________
____
Is your current injury through your current employer? ☐ Yes ☐ No
If it is not through your current employer, please list the name of the employer that it is through, along with a phone number.
Employer Name: ______________________ Phone: ______________

Symptoms

My pain is: ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

Check the boxes that best describe what your pain feels like.

☐ Throbbing	☐ Shooting	☐ Stabbing	☐ Burning	☐ Sharp	☐ Tingling
☐ Numb	☐ Tender	☐ Pressure	☐ Deep	☐ Aching	☐ Cramping
☐ Heaviness	☐ Diffuse	☐ Dull	☐ Gnawing	☐ Localized	☐ Superficial

What makes your pain worse?

☐ Bending	☐ Coughing	☐ Daily Activities	☐ Driving	☐ Everything	☐ First Steps
☐ Going Downstairs	☐ Going Upstairs	☐ Kneeling	☐ Lifting	☐ Lying Down	☐ Neck Movement
☐ Nothing	☐ Reaching	☐ Sitting	☐ Sneezing	☐ Squatting	☐ Standing
☐ Stretching	☐ Twisting	☐ Weather Changes	☐ Walking	☐ Work Activities	

☐ Other, Explain : ______________________________

The pain is: ☐ At Rest ☐ Continuous ☐ In the Night ☐ In the Morning
☐ Intermittent ☐ On Activity ☐ Spontaneous

Does your pain make you: *(check all that apply)* ☐ Depressed ☐ Angry ☐ Frustrated ☐ Helpless/Hopeless

Does your pain interfere with any of the following: ☐ Sleep ☐ Daily Activities ☐ Work

Patient Name: ______________________________ Date of birth: ______________

Family History

Check if any of your BLOOD relatives have had any of the following:

Disease	Relationship to You
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, stroke	
High Blood Pressure	
Kidney Disease	
Neurologic Condition	
Bleeding disorder	
Other, please list	

Social History

Educational Background:

☐ None ☐ Home-Schooling ☐ Elementary School ☐ High School ☐ College Graduate

☐ GED ☐ Grad School ☐ Some College ☐ Trade School ☐ Technical School

☐ Post-College ☐ Medical School ☐ Law School

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

How many children do you have? ______________________________

Do you use tobacco? ☐ Current ☐ Former ☐ Never ☐ Unknown

Type: ____________ Units/day: ____________ Years used: ____________ Pack Years: ____________

Ever tried to quit? ☐ Yes ☐ No Year quit: ____________ Longest tobacco free: ____________

Relapse reason: ______________________ Passive smoke exposure? ☐ Yes ☐ No

Smoker Status (Meaningful Use)

☐ Current Every Day Smoker ☐ Smoker, Current Status Unknown ☐ Former Smoker

☐ Current Some Day Smoker ☐ Never Smoker ☐ Unknown if Ever Smoked

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

How frequently do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially ☐ Never

Do you use recreational drugs?

☐ Yes ☐ No ☐ Former ☐ Never ☐ Rarely ☐ Occasionally ☐ Often

What? ______________________ How often? ______________________

Exercise?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ 2-3 times/week ☐ 3-4 times/week ☐ Daily

Patient Name: ____ Date of birth:_____________

Allergies

Allergy	Reaction

Medication History

Pharmacy Name: ___________________________________Phone Number: ____________________

Please provide a list of current prescription medication and over the counter medication:

Medication Name	Dose	Frequency	Pharmacy

Have you taken any medications in the past for your current pain problem, even if they didn't work? ☐ Yes ☐ No

If yes, please list (be sure to include any nonprescription medications such as Tylenol, Bengay, etc.)

Name	Why Stopped

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff of Omega Rehabilitation & Spine.

Patient/Guardian Signature __________________________________ Date: ____________________

Patient Name: ______________________________ Date of birth:________________

Please check any previous treatments for current pain:

☐ No Prior Modalities ☐ Acupuncture ☐ Biofeedback ☐ Hypnosis ☐ Manipulation/Chiropractor
☐ Physical Therapy ☐ Traction ☐ Work Hardening ☐ Herbal Remedies ☐ Tens Unit
☐ Injections ☐ Counseling

List any tests for your pain:

☐ X-ray ☐ CT Scan ☐ MRI ☐ Mylogram
☐ Bone Scan ☐ EMG ☐ Blood Tests

Past Medical History

Please check all that apply:

☐ AIDS/HIV ☐ Aneurysm ☐ Arthritis ☐ Asthma ☐ Bleeding Disorder ☐ Cancer
☐ Chem. Dependency ☐ CA Colon ☐ CA Lung ☐ CA Breast ☐ CA Prostate ☐ CA Cervical
☐ COPD ☐ Depression ☐ Diabetes ☐ Fibromyalgia ☐ Heart Attack ☐ Heart Disease
☐ Hepatitis ☐ Hypercholesterolemia ☐ Hypertension ☐ Hypothyroidism ☐ Jaundice ☐ Kidney Disease
☐ Liver Disease ☐ Murmur ☐ Osteoarthritis ☐ Pacemaker ☐ Peptic Ulcer Disease ☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease ☐ Post-op Nausea/ Vomiting ☐ Reflux ☐ Rheumatic Fever ☐ Seizure Disorder ☐ Sleep Apnea
☐ Stroke ☐ Other, please list: ____

Past Surgical History

List all previous surgeries:

Date (Month/Year)	Procedure

Patient Name: ______________________________ Date of birth:______________

Work History

Are you employed? ☐ Yes ☐ No

Occupation: ______________________________

If yes, where: ______________________________

Are you on worker's compensation? ☐ Yes ☐ No

Is your employer contesting? ☐ Yes ☐ No

Do you have an attorney? ☐ Yes ☐ No

If yes, attorney name: ______________________________

When did you last work? ________/________/________

Are you currently working? ☐ Yes ☐ No

Do you have work restrictions? ☐ Yes ☐ No

Would you return to work with restrictions? ☐ Yes ☐ No

Have you missed work because of your pain? ☐ Yes ☐ No

Do you want to go back to work? ☐ Yes ☐ No

Do you want permanent disability? ☐ Yes ☐ No

Psychological History

Have you ever been treated for emotional/behavioral disorder? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

If yes, when: ______________________________

Do you currently have ACTIVE suicidal thoughts? ☐ Yes ☐ No

Do you have a history of suicidal attempts? ☐ Yes ☐ No

Do you have a history of drug abuse? ☐ Yes ☐ No

Do you have a history of alcohol abuse? ☐ Yes ☐ No