BRENTWOOD
spine + sport

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Email: _____
Social Security #: _____ Driver's Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

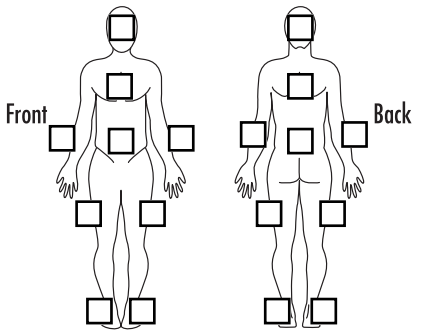
Is this? ☐ Work Related ☐ Auto ☐ Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (How you feel today?)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain



MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No Describe: _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ Yes ☐ No Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

NO	YES	CONDITION
☐	☐	History of Recent Infection
☐	☐	Recent fever
☐	☐	HIV / AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (Date)
☐	☐	Dizziness / Fainting
☐	☐	Numbness in Groin / Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer / Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

NO	YES	CONDITION
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births: _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy / Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low / Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries / Medications: _____

_____

_____

_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

If you were unable to submit your form, please email it directly to bkleinbrodt@yahoo.com

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