FANWOOD
BACK RELIEF CENTER

Name_____ Date_____

Address_____ City _____

State_____ Zip_____ Date of Birth _____ Age_____ Sex: M F

Phone Number _____ Cell / Home / Work

Email Address _____ Your occupation _____

Social Security Number (insurance purposes only) _____

Emergency Contact & Phone Number _____

Your Primary Care Physician (PCP)_____Phone_____

How did you hear about us? (Newspaper ad, Online, Existing Patient) _____

Do you have health insurance? Yes / No Is your injury related to an automobile or work-related accident? Yes / No

PRIMARY COMPLAINT: _____

When did it start? _____ Have you had this condition before? ☐ Yes ☐ No

Type of pain (please circle one): sharp, dull, aching, shooting, numbness, tingling

Does the pain travel? ☐ Yes ☐ No If yes, from where to where? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month? Is condition getting worse? ☐ Yes ☐ No

Rate the pain from 1-10: At its worst _____ At the present time ____ At least severe _____

What makes it feel better? _____ What make it feel worse? _____

What do you think caused the problem?_____

List the activities that this condition prevents you from doing: _____

List past treatment for this condition and if they helped: _____

SECOND COMPLAINT: _____

When did it start? _____ Have you had this condition before? ☐ Yes ☐ No

Type of pain (please circle one): sharp, dull, aching, shooting, numbness, tingling

Does the pain travel? ☐ Yes ☐ No If yes, from where to where? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month? Is condition getting worse? ☐ Yes ☐ No

Rate the pain from 1-10: At its worst _____ At the present time ____ At least severe _____

What makes it feel better? _____ What make it feel worse? _____

What do you think caused the problem?_____

List the activities that this condition prevents you from doing: _____

List past treatment for this condition and if they helped: _____

THIRD COMPLAINT: _____

When did it start? _____ Have you had this condition before? ☐ Yes ☐ No

Type of pain (please circle one): sharp, dull, aching, shooting, numbness, tingling

Does the pain travel? ☐ Yes ☐ No If yes, from where to where? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month? Is condition getting worse? ☐ Yes ☐ No

Rate the pain from 1-10: At its worst _____ At the present time ____ At least severe _____

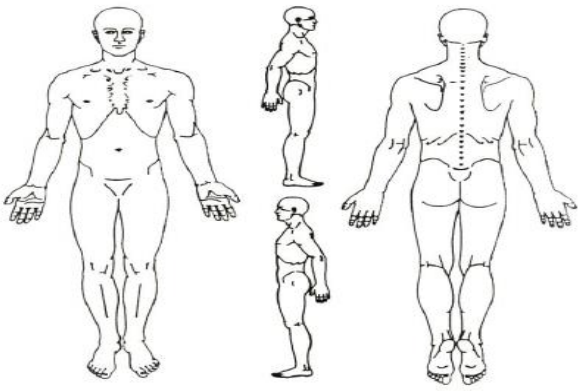
What makes it feel better? _____ What make it feel worse? _____

What do you think caused the problem?_____

List the activities that this condition prevents you from doing: _____

List past treatment for this condition and if they helped: _____

Indicate Your Pain on the Diagram:



Do you currently have, or have you had any of the following conditions or symptoms? Circle all that apply:

Headaches	Wrist of hand pain	Stomach Problems	Depression
Knee Pain	Numbness/tingling	Ringing in ears	Anxiety
Neck Pain	Chest Pain	Loss of balance	Shoulder pain
Low back pain	Heart Conditions	Nervousness	Kidneys
Hip Pain	High blood pressure	Cancer	Bladder
Fatigue	Shortness of breath	HIV	Arthritis
Vertigo	Loss of smell/taste	Dizziness	Joint swelling
Jaw pain	TMJ	Insomnia	Stomach/GI
Diabetes (Insulin)	Diabetes (No Insulin)		

Other:_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?
Please explain in the following section any information that you feel would be helpful to the doctor.

Notes (Office Use Only):

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:

1) May we confirm your appointments by email, text or phone? Yes No

2) May we leave a message on your answering device at home or cell phone? Yes No

3) May we discuss your condition with any members of your family? Yes No

If yes, provide names: _____

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient, but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency it was not possible to obtain a signature
___ other (please provide details): _____

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date