TEXAS SPINE & INJURY CENTER

PATIENT INFORMATION FORM

General Information

Date:	Name: _____ First Last MI			SS #: _____-_____-_____
Home phone:	Cell phone:	Sex: ❑ Male ❑ Female	Age: _____	Birth date: ____/____/____ MM DD YY
Address:		City/State:		Zip:
Email:		❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed ❑ Partnered ❑ Minor		
Occupation:		Patient employer/school:		Employer/School phone:
Spouse or Parent Name: _____ First _____ Last _____ MI			Birth Date: ____/____/____ MM DD YY	SS #: _____/_____/_____
Spouse or Parent Employer:		How did you hear about us?		

Emergency Information

In case of emergency, contact: _____ First _____ Last		Relationship:
Home phone:	Work phone:	Cell phone:
Primary care physician name:		Primary care physician phone number:

Accident Information

Is condition due to an accident? ❑ yes ❑ no	Date of accident:	Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other	To whom have you made a report of your accident? ❑ Auto insurance ❑ Employer ❑ Worker's Comp ❑ Other
Attorney name (if applicable):			Attorney phone (if applicable):

Name: _____ **Date:** _____

Insurance

Who is responsible for this account?	Relationship to patient:	SS #: _____ - _____ - _____
Primary insurance company name:	Subscriber Name:	
DOB:	ID #:	Group #:
Is patient covered by additional insurance? ❑ yes ❑ no	Secondary insurance company name:	Subscriber Name:
DOB:	ID #:	Group #:

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and deterring insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of patient, parent, guardian or personal representative | Print name of patient, parent, guardian, or personal representative

_____ _____

Date | Relationship to patient

Patient Condition

Reason for your visit?		When did your symptoms begin?
Is this condition getting progressively worse? ❑ yes ❑ no ❑ unknown	Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10	
Type of pain: ❑ sharp ❑ dull ❑ throbbing ❑ numbness ❑ aching ❑ burning ❑ shooting ❑ cramping ❑ tingling ❑ swelling ❑ stiffness ❑ other		How often do you have this pain?
Is it constant or does it come and go?	Does it interfere with your (check all that apply): ❑ sleep ❑ work ❑ recreation ❑ daily routine	Activities that are painful to perform (check all that apply): ❑ sitting ❑ standing ❑ bending ❑ walking ❑ lying down

Treatment you are receiving or have received for this condition:

❑ Medical Care _____ ❑ Chiropractic Care _____

❑ Physical Therapy _____ ❑ Other _____

Name: _____ **Date:** _____

Review of Systems

Constitutional	No	Yes	Respiratory	No	Yes	Eye	No	Yes
Excessive thirst	❑	❑	Chest pain	❑	❑	Eye pain	❑	❑
Chills	❑	❑	Chronic cough	❑	❑	Failing vision	❑	❑
Convulsions	❑	❑	Difficulty breathing	❑	❑	Far sighted	❑	❑
Dizziness	❑	❑	Spitting up blood	❑	❑	Near sighted	❑	❑
Fainting	❑	❑	Spitting up phlegm	❑	❑	Glaucoma	❑	❑
Fatigue	❑	❑	Wheezing	❑	❑	Blurred vision	❑	❑
Fever	❑	❑	Asthma	❑	❑	**Ears, Nose, and Throat**		
Weight loss	❑	❑	**Gastrointestinal**			Ringing in ears	❑	❑
Loss of sleep	❑	❑	Excessive belching	❑	❑	Colds	❑	❑
Night sweats	❑	❑	Excessive gas	❑	❑	Deafness	❑	❑
Psychiatric			Colitis	❑	❑	Earaches	❑	❑
Nervousness	❑	❑	Colon trouble	❑	❑	Ear discharge	❑	❑
Depression	❑	❑	Constipation	❑	❑	Ear noise	❑	❑
Mood swings	❑	❑	Diarrhea	❑	❑	Enlarged glands	❑	❑
Musculoskeletal			Difficult digestion	❑	❑	Enlarged thyroid	❑	❑
Arthritis	❑	❑	Bloated abdomen	❑	❑	Gum trouble	❑	❑
Bursitis	❑	❑	Excessive hunger	❑	❑	Hay fever	❑	❑
Foot trouble	❑	❑	Gallbladder trouble	❑	❑	Hoarseness	❑	❑
Hernia	❑	❑	Hemorrhoids	❑	❑	Nasal obstruction	❑	❑
Neck pain	❑	❑	Intestinal worms	❑	❑	Nose bleeds	❑	❑
Mid back pain	❑	❑	Jaundice	❑	❑	Sinus infections	❑	❑
Low back pain	❑	❑	Liver trouble	❑	❑	Sore throat	❑	❑
Fractures	❑	❑	Nausea	❑	❑	**Genitourinary**		
Cardiovascular			Stomach pain	❑	❑	Blood in urine	❑	❑
Hardening of arteries	❑	❑	Poor appetite	❑	❑	Frequent urination	❑	❑
High blood pressure	❑	❑	Vomiting	❑	❑	Kidney infection	❑	❑
Low blood pressure	❑	❑	Vomiting of blood	❑	❑	Painful urination	❑	❑
Chest pain	❑	❑	**Skin**			Prostate trouble	❑	❑
Poor circulation	❑	❑	Bruise easily	❑	❑	Seizures	❑	❑
Rapid heartbeat	❑	❑	Dryness	❑	❑	Are you pregnant?	❑	❑
Slow heartbeat	❑	❑	Hives/allergy	❑	❑	**Neurological**		
Swelling of ankles	❑	❑	Itching	❑	❑	Tremors	❑	❑
			Varicose veins	❑	❑	Fainting spells	❑	❑
						Coordination difficulty	❑	❑

Habits

	Yes	No	If yes, please describe:
Smoking	❑	❑	Packs per day: ❑ 0-½ ❑ ½-1 ❑ 2 or more How long? _____
Alcohol consumption	❑	❑	Number of drinks per day _____ # of drinks per week _____
Other drug use (street drugs)	❑	❑	
Exercise	❑	❑	❑ Daily ❑ Weekly ❑ Monthly Type _____

Medications

Please list all currently used medications and dosage. Include prescription and non-prescription drugs.

_____

_____

Name: _____ **Date:** _____

Allergies

Please list all known allergies, especially to medications.

_____

Surgeries

YEAR	BODY REGION	PROCEDURE

Family History

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy-Asthma	Alcohol abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (describe)	
Father																			
Mother																			
Brothers & Sisters																			

Prior Auto Accidents/Work Injuries

YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT

Medical Illnesses

List current and past illnesses not mentioned above.

_____

_____

Patient/Responsible Party Signature: x_____ Date: _____