

Tel: 860-269-3225 • Fax: 860-269-3227

www.spinesportscare.com

PATIENT INFORMATION							
Patient Name (Last, First, MI)			Date of Birth		Age		
				/			
Mailing Address		City/State		Zip			
Street Address (if different)		City/State		Zip			
SS# Marital Status	Name of Spouse	e La	anguage	Oth	er;		
	w		English Span	ish 🔤 Spec	cify		
RaceAmerican Indian/	Native Hawaiian/	· ·		Other;			
White Alaska Native Asian	Other Pacific Islander	Black/African Americ	an Decline to Answer	Specify	/		
Ethnicity							
		e to Answer	1				
Home Telephone # Work #	Cell #		Email				
)					
Emergency Contact Phone #		Relationship					
)						
Who referred you to this office? (e.g., Name of physician	n, family/friend, website, advertisem	ent)					
Primary Care Physician	City/State		Phone				

EMPLOYMENT INFORMATION						
Occupation Employer's Name Phone						
Employer's Address		City/State		Zip		

INSURANCE INFORMATION					
Primary Insurance	ID#	Group #			
Subscriber's Name	Date of Birth	Relationship			
Subscriber's Employer	City/State	Zip			
Secondary Insurance	ID#	Group #			
Subscriber's Name	Date of Birth	Relationship			
Subscriber's Employer	City/State	Zip			

Complete below if this injury is due to a motor vehicle accident or work injury

Motor Vehicle Accident Work Injury		
Law Firm / Attorney Name		Phone #
Address	City / State	Zip
Insurance	ID#	Group #
Date of Injury	Claim Mailing Address	
Worker's Comp. Carrier	Adjuster	Phone #
Has this injury been reported to someone at work?		Is this visit approved?

Anginal/Chest pain/lifegular heart beat [] [] Diabetes: Type I or Type II [] []		· · · · · · · · · · · · · · · · · · ·	DATE:								PATIENT NAME:
Children: YES NO Ages: Educational Level: Grade School High School College Graduate School Other Smoking History: Never Former Smoker Current Smoker Years: Anount:					HISTORY	SOCIAL & FAMILY					
Educational Level: Grade School High School Current Smoker Graduate School Other Smoking History: Never Former Smoker Current Smoker Years: Amount:		Alone		hildren	Child/C	e Significant Other	Spouse	S S		Family	ive with:
simoking History: Never Former Smoker Current Smoker Yess: Amount: Substance Abuse: Yes NO Type:						Ages:	□ NO	□ N		YES	Children:
intending History: Never Former Smoker Current Smoker Yess: Amount: Substance Abuse: Yes NO Type:			Other	School	Graduate		— — Hiah School	Пні	chool	Grade Sc	ducational Level:
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Please list any surgeries, date performed, and by whom											Туре:
						m	nd by whom	l, and by	formed,	eries, date perf	lease list any surge
MEDICATION					DN	MEDICATIO					
ease list current prescriptions, vitamins, supplements, and herbals						nts, and herbals	supplements, an	is, suppl	vitamins	escriptions, v	ase list current pr

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PATIENT NAME: _____

DATE: _____

		PAIN QUESTIONNAIRE		
Vhen did your pain begin? s your pain related to an injury? Please describe how it began:				
What do you hope to accomplish	h or gain from treatment?			
Where is your pain?				
Head Neck Rt / Lt / Both Shoulder Rt / Lt / Both Upper Arms Rt / Lt / Both	☐ Forearm Rt / Lt / Bo ☐ Hand Rt / Lt / Bo ☐ Upper Back Rt / Lt / Bo ☐ Chest Rt / Lt / Bo	Both 🗌 Buttocks Rt Both 🗌 Hips Rt	Rt / Lt / Both Gro Rt / Lt / Both Kne Rt / Lt / Both Calf Rt / Lt / Both Foo	lf Rt / Lt / Both
Describe your pain and specify	/y where?			
Sharp	Stabbing	Dull	Act	hy
Shooting				amping
Numbness		Pressure-like	e Oth	her
How often do you experience t	the pain?			
Constantly	Frequently	Intermittently		ccasionally
What aggravates your pain?				
-	Sitting for Long Periods	Standing		nding for Long Periods
	Walking for Long Periods	Lying Down		king Forward
	Coughing	Sneezing	Strai	ining
	Sleeping	Specific Movement(s)		
Other				
What relieves your pain?	_			
Sitting Down		Valking Lying Down		Therapy
Moist Heat/Hot Shower		Sleeping Exercise	Stretching	Rest
	Other			
What medications are you current				
Since your pain began, is it: Have you resumed your normal ac Are you disabled from your usual If so, what is the date you were las	I employment?		same be of Work	
What type of treatment have you	u received so far?	PREVIOUS TREATMENT		
Acupuncture				
Epidural Steroid Injections / Trig	gger Point Injections or Nerve Block	ks		
Surgery				
_ Other				
and the first strength	the second subs	DIAGNOSTIC TESTING		
What diagnostic tests have you	-			
MRI Cervical Spine		mbar Spine		
X-Rays Cervical Spine		Lumbar Spine		
OAT Otan		/V		
		For Office Use Only	/ \\	
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