Dynamic Health Wellness & Rehabilitation Center

Confidential Patient Information:

PATIENT INFORMATION		
Name: Last:	First:	M.I.
Address: Street:	City:	State, Zip:
Social Security #: - -	Date of Birth: - -	
Gender: Male Female		Marital status S _____ M _____ D _____ W_____
Contact Information: Home Phone:	Office:	Cell:
Email :		
Employer Name:	Title:	Phone:
Address:		
City:	State:	Zip:
Insured Information:		
Name: Last:	First:	M.I.:
Relationship to Patient:	S.S.N.:	D.O.B.:
Address:		
Name of Employer:		

Conditions:

Past / Present

- ☐ ☐ Neck Pain
- ☐ ☐ Shoulder Pain (R___ L___)
- ☐ ☐ Pain in Upper Arm or Elbow (R___ L___)
- ☐ ☐ Hand Pain (R___ L___)
- ☐ ☐ Pain in Wrist (R___ L___)
- ☐ ☐ Upper Back Pain (R___ L___)
- ☐ ☐ Lower Back Pain (R___ L___)

Past / Present

- ☐ ☐ Pain in Lower Leg (R___ L___)
- ☐ ☐ Pain in Upper Leg (R___ L___)
- ☐ ☐ Pain in Hip (R___ L___)
- ☐ ☐ Pain in Knee (R___ L___)
- ☐ ☐ Jaw Pain (R___ L___)
- ☐ ☐ Pain in Ankle or Foot (R___ L___)
- ☐ ☐ Headache

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Confidential Patient Information:

Past / Present	Past / Present	Past / Present
☐ ☐ AIDS/HIV	☐ ☐ Herniated Disc	☐ ☐ Tonsillitis
☐ ☐ Allergy Shots	☐ ☐ High Cholesterol	☐ ☐ Tumors/Growths
☐ ☐ Anemia	☐ ☐ Kidney Disease	☐ ☐ Ulcer
☐ ☐ Anorexia	☐ ☐ Measles	☐ ☐ Whooping Cough
☐ ☐ Appendicitis	☐ ☐ Migraine Headaches	☐ Other_____
☐ ☐ Arthritis	☐ ☐ Mononucleosis	☐ Other _____
☐ ☐ Asthma	☐ ☐ Multiple Sclerosis	
☐ ☐ Bronchitis	☐ ☐ Osteoporosis	**Social History:**
☐ ☐ Cancer	☐ ☐ Pacemaker	☐ ☐ Tobacco_____Packs per Day _____Years
☐ ☐ Chicken Pox	☐ ☐ Parkinson's Disease	☐ ☐ Alcohol _____Drinks/Week
☐ ☐ Depression	☐ ☐ Pinched Nerve	☐ ☐ Coffee/Tea/Caffeinated Drinks_____Per Day
☐ ☐ Diabetes	☐ ☐ Pneumonia	
☐ ☐ Emphysema	☐ ☐ Prostate Problems	**Women Only:**
☐ ☐ Fractures	☐ ☐ Psychiatric Care	☐ ☐ Birth Control Pills
☐ ☐ Gout	☐ ☐ Rheumatoid Arthritis	☐ ☐ Menstrual Flow
☐ ☐ Heart Disease	☐ ☐ Rheumatic Fever	☐ ☐ Breast Implants
☐ ☐ Hepatitis	☐ ☐ Stroke	
☐ ☐ Hernia	☐ ☐ Thyroid Problems	

If a family member has had any of the following please mark the appropriate box:

☐ Arthritis ☐ Epilepsy ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Chronic Headaches ☐ Chronic Back Pain
☐ Kidney Disease ☐ Rheumatoid Arthritis ☐ Mental Illness ☐ Osteoporosis ☐ Lupus ☐ Lung Problems
☐ High Blood Pressure ☐ Other:_____

What is your reason for treatment?

☐ Optimizing/Maintaining My Health ☐ I have symptoms.

If so, when did you first notice the symptoms?_____

Where specifically are your symptoms located?

Is your condition getting better, worse, or staying the same? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Are your symptoms:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Rate the severity of your symptoms. (0= none to 10 = severe/unbearable) 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms (% of the day)?
☐ Constant (90-100%) ☐ Frequent (50-75%) ☐ Intermittent (25-50%) ☐ Rare (<25%)

What makes your symptoms worse?

What makes your symptoms better?

What treatment(s) have you received for your condition: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other

How tall are you? _____' _____'' What is your present weight? _____ lbs.

Are you currently taking any prescription medication? If yes please list:

1._____ **2._____**

3._____ **4._____**

5._____ **6._____**

Name/Phone number of other doctor(s) you have seen for your condition; Dates of last exams; Surgeries:

Name: Phone: Date of last exam:

Surgeries:

Name: Phone: Date of last exam:

Surgeries:

How Did you hear about Dynamic Health Wellness & Rehabilitation Center?

Please read and sign the following:

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify the doctor and or staff immediately whenever I have a change of information or in my health condition.
- I consent to the release of my confidential and patient information in the possession of Dynamic Health Wellness & Rehabilitation Center to other health care professionals whom I am referred and to the insurance company or other entity responsible for payment.
- I authorize Dynamic Health Wellness & Rehabilitation Center and their staff to perform any services needed during diagnosis and treatment. I also authorize payment of insurance benefits to Dynamic Health Wellness & Rehabilitation Center for services rendered.
- Our policy requires payment for services rendered at time of visit unless other arrangements have been made with the office manager. I understand that I am ultimately liable for all charges for services rendered.
- All HIPPA guidelines and requirements are followed in this office.

Signed (patient or authorized person)_____ Date:_____