MODESTO PHYSICAL MEDICINE

PATIENT INFORMATION

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # (Cell)_____ (Home) _____ (Other) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Occupation: _____ Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

ACCIDENT INFORMATION

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Claim #: _____ Date of Injury: _____

HEALTH OR AUTO INSURANCE INFORMATION

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD(S)

ASSIGNMENT AND RELEASE (INSURED PATIENTS)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: _____ **DATE** _____

1933 Coffee Road
Modesto, CA 95355
(209) 838-3434
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HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Low Back Pain (L/R)	❑ Elbow Pain (L/R)	❑ Blurred Vision	❑ Sudden Weight Loss
❑ Mid Back Pain (L/R)	❑ Hip Pain (L/R)	❑ Headaches	❑ Pins/Needles in Legs
❑ Neck Pain (L/R)	❑ Leg/Knee Pain (L/R)	❑ Nervousness	❑ Pins/Needles in Arms
❑ Wrist Pain (L/R)	❑ Ankle Pain (L/R)	❑ Tension/Stress	❑ Pins/Needles in Hands
❑ Hand Pain (L/R)	❑ Foot Pain (L/R)	❑ Night Pain	❑ Cold Feet
❑ Arm Pain (L/R)	❑ Fatigue	❑ Allergies	❑ Fever
❑ Shoulder Pain (L/R)	❑ Dizziness	❑ Jaw Problems	❑ Sleeping Difficulties

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cataracts	❑ Gout	❑ Migraines	❑ Stroke
❑ Allergy Shots	❑ Chemical Dependency	❑ Hair Loss	❑ Multiple Sclerosis	❑ Thyroid Problems
❑ Anorexia	❑ Diabetes	❑ Hernia	❑ Osteoporosis	❑ Ulcers
❑ Arthritis	❑ Difficulty Weight Loss	❑ Herniated Disc	❑ Parkinson's Disease	❑ Water Retention
❑ Bleeding Disorders	❑ Food Cravings	❑ High Cholesterol	❑ Polio	❑ Weight Gain
❑ Brittle Nails	❑ Fractures	❑ Hyperactivity	❑ Prosthesis	
❑ Bulimia	❑ Glaucoma	❑ Kidney Disease	❑ Restlessness	
❑ Cancer	❑ Goiter	❑ Liver Disease	❑ Rheumatoid Arthritis	

❑ Other _____

Are you currently under medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE 6/8/2021**

Reviewed by SIGNATURE (X) _____ **DATE 6/8/2021**

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NEUROPATHY HISTORY

Is there a certain time of the day any of these problems are better or worse? _____

List the things you have used for these problems? _____ Gabapentin _____ Neurontin _____ Lyrica

_____ Cymbalta _____ Physical Therapy _____ Pain Meds _____ Aleve _____ Tylenol

_____ Motrin _____ Chiropractic _____ Massage _____ Injections

Is your balance/walking ability affected? Yes No

What do you think is causing your problem? _____

Name the different types of doctors you have seen for your condition: _____

Have your symptoms: **_____ Improved** **_____ Worsened** **_____ Stayed the same**

List anything that makes your condition worse: _____

List anything that makes your condition better: _____

How would you describe your symptoms? Please check all that apply

_____ Aching Pain _____ Numbness _____ Hot Sensation _____ Cramping

_____ Stabbing Pain _____ Tingling _____ Throbbing Pain _____ Swelling

_____ Sharp Pain _____ Pins& Needles _____ Dead Feeling _____Burning

_____Tiredness _____Heavy Feeling _____ Cold Hands/Feet _____ Electric Shocks

Is this condition interfering with any of the following?

_____ Sleep _____ Work _____ Daily Activities _____Housework

_____Recreational Activities _____ Walking _____ Standing _____ Shopping

SOCIAL HISTORY

Do you smoke? _____Yes _____ No **If yes, how may cigarettes daily? _____**

Do you drink? _____Yes _____ No **If yes, how may cigarettes daily? _____**

Do you exercise regularly? _____Yes _____ No **If yes, please describe & how often?**

_____

_____

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How would you rate your pain in the last week?

NO PAIN **WORST PAIN POSSIBLE**

0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN **WORST PAIN POSSIBLE**

0 1 2 3 4 5 6 7 8 9 10

PREVIOUS HEALTH HISTORY

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ Signature _____

Please give name, address, and office phone number of your primary care physician.

Name _____ Phone _____ Address _____

When were you last seen there? _____

May we send them updates on your treatment/condition? _____ Yes _____ NO

List all allergies/sensitivities to medication, food, and other items here:

Item you react to:	Reaction:
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____

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