



Confidential Patient Case History

Name: _____ DOB: _____ Age: _____

Address: _____ # of children: _____

_____ Marital Status: S M D W

Work #: _____ Spouse's Name: _____

Home #: _____ Spouse's Phone # _____

Cell #: _____

Cell Phone Carrier: _____

Email: _____ Employer: _____

How did you hear about us?

Yelp Zoc Doc Google Community Events Referred by: _____

Health Information:

What is your major complaint?: _____

Other Complaints: _____

How long have you had this condition?: _____

Have you had this or similar condition in the past?: _____

What activities aggravate your condition?: _____

Is this condition getting progressively worse? Yes No Constant Comes & Goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

How long has it been since you really felt good? _____

Other doctors who have treated this condition: _____

List any surgical operations and year performed: _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills

Tranquilizers Insulin Birth Control Other _____

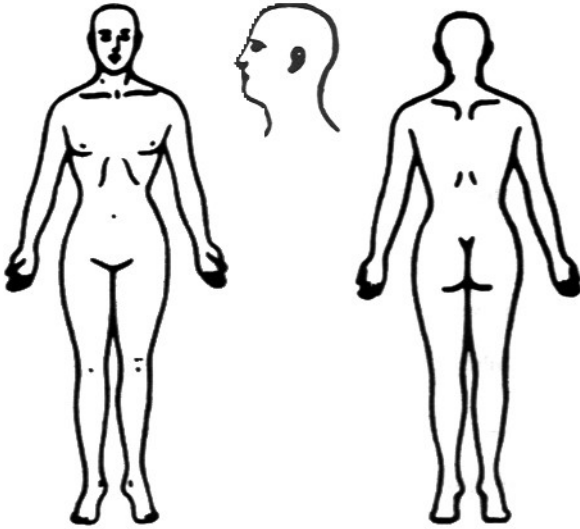
Age of mattress: _____ Comfortable Uncomfortable

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Have you been in an auto accident? Past Year Past 5 years Never

Please Describe: _____

Date of Last Physical Examination _____



Have you ever suffered from?

- | | | |
|------------------------|------------------------------|-----------------------------|
| 1. Dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Backaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Heart trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Headaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Neuritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Digestive Disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Nervousness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Sinus trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Neck pain | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? YES NO

Do you have health insurance? YES NO

Name of Company _____

INSURANCE ASSIGNMENT OF BENEFITS- Payment of Hudson Sport & Spine Bills: I would like a “third party payer” (for example, my insurance company or its related organizations) to pay the bills for my services at Hudson Sport & Spine, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the “third party payer” be made to Hudson Sport & Spine on my behalf for services furnished to me by or in Hudson Sport & Spine, I assign the benefits payable to physician services to the physician or organization furnishing the services.

Patient's Signature: _____

Date _____

Guardian or Spouse Signature: _____

SS# _____

Doctor's Signature: _____

Date _____