Ultima Sports and Spine

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The information you provide below helps us to better understand your needs and how to help you reach your health goals. Please write legibly and answer all questions completely. Ask the office staff if you have any questions or need further clarification.

Patient Intake Form

Today's Date: _____

Name:

_____
First Middle Last

Street Address: _____ Apartment number: _____

City: _____ State: _____ Zip code: _____

Phone Numbers: Home: _____ Work: _____

Cell: _____ Other: _____

- Preferred # for contacting you and for appointment reminders: ❑ Home ❑ Work ❑ Cell ❑ Other
- Is it OK to receive text message appointment reminders from our clinic? ❑ Yes ❑ No
- What is your e-mail address: _____
- May we contact you via e-mail regarding important clinic information? ❑ Yes ❑ No

How did you hear about our clinic? ❑ Website ❑ Advertisement ❑ Friend/Family ❑ Other: _____

FOR INSURANCE BILLING PURPOSES:

SS#: _____

Date of Birth: _____

Age: _____ Gender (circle) M F

Policy Holders's Name: _____ ❑Self ❑Spouse ❑Parent

Name of Insurance Company: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Relationship Status (circle): Single Married Partnership Separated Divorced Widowed

Emergency Contact: _____ Phone Number: _____

Employment Information:

Employer & Address:

_____

_____

_____

INITIAL COMPLAINT(S):

Pain scale – Based on a scale of 0 to 10 with 10 being the most severe. Please rate each symptom.

Jaw Pain: ❑Right ❑Left ❑Both Sides Jaw "pops" or "clicks": ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Neck Pain: ❑Right ❑Left ❑Both Sides ❑Neck Stiffness ❑Muscle Spasms

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Pain increased while rotating head to the: ❑Right ❑Left
Pain increased while bending head: ❑Forward ❑Backward ❑Right Side ❑Left Side

Headaches:

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Location: ❑ Front ❑ Back ❑ Temples ❑ Forehead ❑ Behind the Eyes

Shoulder Pain and/or Limited Movement: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Wrist Pain: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Hand Pain: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Arm, Hand & Finger Symptoms: ❑Numbness ❑Tingling ❑Pins & Needles ❑Weakness

❑Right ❑Left ❑Both Sides

Degree Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Back Pain: ❑Upper ❑Mid ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe **Muscle Spasms:** ❑Right ❑Left ❑Both Sides

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Low Back Pain: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe **Muscle Spasms:** ❑Right ❑Left ❑Both Sides

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Hip Pain: ❑Right ❑Left ❑Both Sides Hip Replacement: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

Knee Pain: ❑Right ❑Left ❑Both Sides

Pain Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

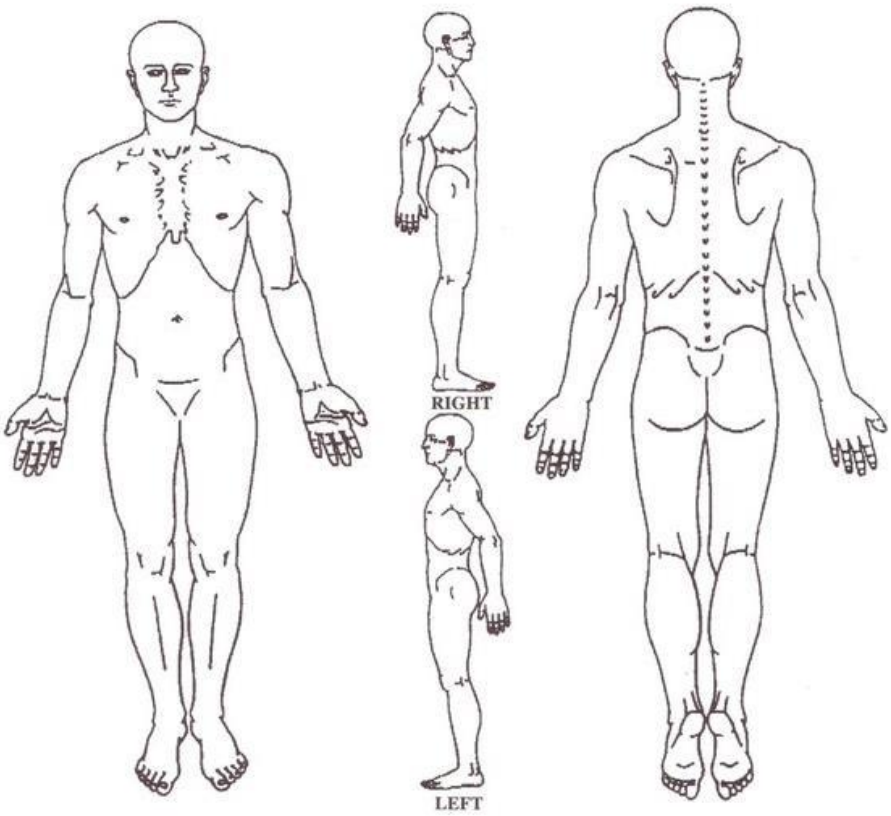
Leg, Foot & Toe Symptoms: ❑Numbness ❑Tingling ❑Pins & Needles ❑Weakness

❑Right ❑Left ❑Both Sides

Degree Scale: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Mild ❑ Moderate ❑ Severe

❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent



Please mark the areas of your complaint(s) on the diagram by using the following indicators:

X = Pain
O = Numbness
Z = Tingling
B = Burning
T = Tightness
S = Sharp

PAST MEDICAL HISTORY

Please check if you have or had any of the following medical conditions:

❑AIDS/HIV	❑Cancer	❑Gout	❑Rheumatoid Arthritis
❑Alcoholism	❑Headaches	❑Migraine Headaches	❑Stroke
❑Anemia	❑Chemotherapy	❑Heart Disease	❑Thyroid Problem
❑Diabetes	❑Hepatitis B or C	❑Multiple Sclerosis	❑High Blood Pressure
❑Abdominal Hernia	❑Osteoporosis	❑Arthritis	❑Emphysema
❑Herpes	❑Pacemaker	❑Tumors/Growths	❑Asthma
❑Bleeding Disorders	❑Fatigue	❑High Cholesterol	❑Parkinson's Disease
❑Breast Lump(s)	❑Kidney Disease	❑Pinched Nerve	❑Vascular Disease
❑Bronchitis	❑Liver Disease	❑Pneumonia	❑Prostate Problem
❑Epilepsy/Seizures	❑Ulcers		

❑Other: _____

Allergies: _____

Do you have a psychiatric problem? ❑ Yes ❑ No Explain: _____
Have you ever had any form of heart surgery? ❑ Yes ❑ No Explain: _____
Have you ever been to a Chiropractor before? ❑ Yes ❑ No How long ago? _____
What were you treated for? _____

What diagnostic imaging studies have you had? ❑ X-Rays ❑ CT Scan ❑ MRI Other: _____
Have you been diagnosed with cervical or lumbar disc bulges or disc herniations? ❑ Yes ❑ No

Please list all medications and vitamin/herbal supplements you are currently taking with dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

What hospitalizations, surgeries or injuries have you had? _____
_____
Have you ever been in an automobile accident? ❑ Yes ❑ No
Have you ever had a workers compensation case? ❑ Yes ❑ No
If yes to any of the above, please explain and describe treatment received: _____
_____

FAMILY HISTORY

Do you have a family history **(BLOOD RELATIVE)** of any of the following? **(Please check all that apply.)**

❑Alcoholism	❑Multiple Sclerosis	❑Mental Illness	❑Kidney Disease	❑Thyroid Disorder
❑Skin Diseases	❑Anemia	❑Depression	❑Headaches/Migraines	❑Arthritis
❑Diabetes	❑Heart Disease	❑Asthma	❑Liver Disease	❑High Blood Pressure

❑Cancer (type): _____

Other: _____

SOCIAL HISTORY

Occupation: _____ ❑ Full Time ❑ Part Time ❑ Retired
Do you drink alcohol? ❑ Yes ❑ No How many drinks per week? _____
Do you currently use tobacco? ❑ Yes ❑ No How long? _____ How much daily? _____
Do you use recreational drugs? ❑ Yes ❑ No What kind? _____
Do you exercise? ❑ Yes ❑ No ❑ At Home ❑ At the Gym
How often do you exercise? _____
Are you sexually active? ❑ Yes ❑ No
Do you have any physical limitations or disabilities? ❑ Yes ❑ No Explain: _____

REVIEW OF SYSTEMS (OF YOURSELF)

Circle: Y = Yes, a condition you currently have **NOW** **P = PAST Problem** **N/C =** No Complaint

Height: _____ Weight: _____lbs. Date of last physical exam: _____

Head: ❑ N/C
Y P Headaches
Y P Migraine's
Y P Head Injury
Y P Hair Loss

Eyes: ❑ N/C
Y P Blurred Vision
Y P Double Vision
Y P Eye Pain
Date of Last Eye Exam: _____

Ears: ❑ N/C
Y P Ringing
Y P Dizziness
Y P Ear Pain
Y P Hearing Loss

Nose/Mouth/Throat: ❑ N/C
Y P Stuffiness Y P Jaw Clicks
Y P Loss of Smell Y P Jaw Pain
Y P Nose Bleeds Y P Dental Cavities
Y P Sore Throat Y P Dry Mouth

Neck: ❑ N/C
Y P Pain or Stiffness
Y P Muscle Spasm
Y P Lumps/Goiter
Y P Swollen Glands
Y P Large Thyroid

Respiratory: (Lungs) ❑ N/C
Y P Asthma Y P Cough
Y P Tuberculosis Y P Bronchitis
Y P Spitting Up Blood Y P Pneumonia
Y P Difficulty Breathing Y P Emphysema
Y P Short of Breath Y P Wheezing

Cardiovascular: (Heart) ❑ N/C
Y P Angina Y P Blood Clots
Murmur Y P N
Y P Heart Disease Y P Chest Pain
Chest Pain Y P N Pace

Gastrointestinal: (Digestive Tract) ❑ N/C
Y P Diarrhea Y P Constipation
Ulcers Y P N
Y P Hemorrhoids Y P Gall Bladder Disease

Urinary: (Kidney and Bladder) ❑ N/C
Y P Incontinence Y P Kidney Stones
Y P Frequent Infections Y P Dialysis
Y P Painful Urination Y P Urgency
Y P Blood in Urine Y P Frequency

Musculoskeletal: (Bones, Muscles) ❑ N/C
Y P Weakness Y P Muscle Spasms
Y P Swollen Joints Y P Muscle Pain
Y P Osteoporosis Y P Broken Bones

Neurological: (Nervous System) ❑ N/C
Y P Fainting Y P Seizures
Y P Numbness/Tingling Y P Pins & Needles
Y P Loss of Memory Y P Sciatica

MALE Reproductive: ❑ N/C

Y P Testicle Lumps Y P Testicular Pain

Y P Prostate Issues Y P Erectile Dysfunction

Mental/Emotional/Behavioral: ❑ N/C

Y P Anxiety Y P Stressed

Y P Nervousness Y P Depression

Y P PTSD Y P Substance Abuse

Explain: _____

FEMALE Reproductive: ❑ N/C

Y P Painful Periods Y P PMS

Y P Endometriosis Y P Ovarian Cysts

Y P Hormone Therapy Y P Breast Lump(s)

Are you currently pregnant? ❑Y ❑N

Do you think you are pregnant? ❑Y ❑N

Are you trying to get pregnant? ❑Y ❑N

Number of pregnancies: _____

Date of last GYN exam: _____

OFFICE POLICY REGARDING APPOINTMENTS

Multiple appointments may be given to you for your convenience to minimize waiting and to facilitate the incorporating of these appointments into your daily/weekly schedule. Regardless of how many appointments are scheduled for you each week, please remember that it is the **FREQUENCY OF THE VISITS THAT IS IMPORTANT, and NOT THE DAYS.** If you are unable to keep an appointment for any reason, we require that you call the office immediately to reschedule your visit. If you are late for an appointment you may have to wait for the next available opening. We thank you for your cooperation and understating.

This office does not like to charge a fee for missed office appointments or for failure to notify us within 24 hours of your scheduled appointment. We believe in the honor system and acknowledge that emergencies can occur at any moment. We kindly ask for your courteousness in this matter and keep us informed as soon as possible in the event you need to cancel an appointment or are running late. If, for whatever reason, this becomes a recurring issue, you may be required to pay a no-call/no-show fee of $50 since the scheduled time in our appointment scheduler is allotted for you specifically. Your cooperation in this matter is greatly appreciated.

I understand the above information and guarantee this form was completed correctly and as accurately as possible to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Patient Signature Date: