Patient Re-eval Information

Date: _____

Patient Name_____

Address_____

City_____ State_____ Zip_____

Email_____

Sex: 0 M 0 F Age_____ Birthdate:_____

0 Single 0 Married 0 Widowed 0 Separated 0 Divorced

Occupation:_____

Home Phone_____

Work_____ Cell _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Relationship_____

Home Phone_____

Alt. Phone_____ ext_____

INSURANCE

Is your insurance still the same?_____

Who is responsible and relationship to patient?_____

_____

Insurance Co._____

Policy No._____

Subscriber's Name_____

Birthdate_____ SS#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and sign directly to Dr. Mayer all insurance benefits, if any, otherwise payable to me for services rendered. 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 to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Patient Condition

Reason for visit_____

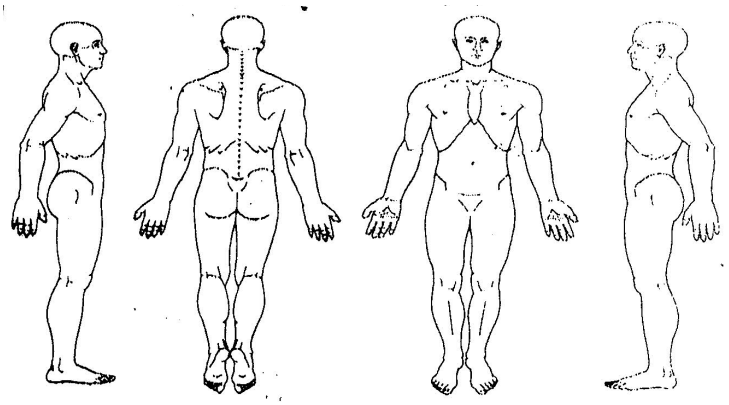
Describe your symptoms _____

_____

When did your symptoms begin? _____

Is this condition getting worse? 0 Yes 0 No 0 Unknown

Indicate on the picture where you have pain, numbness, or tingling.



Rate the severity of your pain from 0 no pain to 10 severe

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

Type of pain: 0 Sharp 0 Dull 0 Throbbing 0Numbness

0 Aching 0 Shooting 0 Burning 0 Tingling 0 Cramps

0 Stiffness 0 Swelling 0 Other

How often is the pain during the day?

0 Constant (76-100%) 0 Frequently (51-75%)

0 Occasionally (26-49%)0 Intermittently (0-25%)

Does it interfere with 0 Work 0 Sleep 0 Daily Routine 0 Recreation

What activities or movements are painful to perform?_____

_____

What activities or movements make the pain better?_____

_____

Who have you seen for your symptoms?_____

_____

What test have you had for your symptoms and when were they performed?

0 MRI date:_____ 0 CT scan date:_____

0 Other _____0 X-Rays date:_____

Have you had similar symptoms in the past? 0 YES 0 NO

Is this condition due to an accident? 0 Yes 0 No If yes please provide the Date_____

Type of accident 0 Auto 0 Work 0 Home 0 Other 0 None

HEALTH HISTORY

What treatment have you already received for your condition? 0 Medications 0 Surgery 0 Physical Therapy 0 Chiropractic 0 None 0 Other __

_____

Name and phone number of other doctor(s) who have treated you for this condition_____

_____

What tests have you had done and when? X-Rays (date)_____ MRI(date)_____

CT Scan(date)_____ Other(date)_____

For each condition listed below, place a check in the Past or the Present column if you have had the condition in the past or presently have one of the conditions listed below:

Past	Present			Past	Present
O	O	Headaches	O	O	Recent Fever
O	O	Neck Pain	O	O	Diabetes
O	O	Upper Back Pain	O	O	High Blood Pressure
O	O	Mid Back Pain	O	O	Stroke (date)_____
O	O	Low Back Pain	O	O	Corticosteroid Use
O	O	Shoulder Pain	O	O	Birth Control Pills
O	O	Elbow/Upper Arm Pain	O	O	Dizziness/Fainting
O	O	Wrist Pain	O	O	Cancer/Tumor (explain)_____
O	O	Hand Pain	O	O	Hepatitis
O	O	Ankle/Foot Pain	O	O	Liver/Gall Bladder Disorder
O	O	Hip/Upper Leg Pain	O	O	Osteoporosis
O	O	Knee/Lower Leg Pain	O	O	Epilepsy/Seizures
O	O	Jaw Pain	O	O	Prostate Problems
O	O	Joint Swelling/Stiffness	O	O	Menstrual Problems
O	O	Arthritis	O	O	Urinary Problems
O	O	Rheumatoid Arthritis	O	O	Currently Pregnant, # weeks_____
O	O	Pain at Night	O	O	Visual Disturbances
O	O	Asthma	O	O	Kidney Problem (explain)_____
O	O	Allergies	O	O	Depression
O	O	Smoke (packs/day)_____	O	O	Alcohol Consumption (drinks/ week)_____

Indicate if an immediate family member has had any of the following:

0 Rheumatoid Arthritis 0 Heart Problems 0 Diabetes 0 Cancer 0 Lupus0 High Blood Pressure 0_____

List all the prescription and over the counter medications, and nutritional/herbal supplements your are taking_____

_____

List all the surgical procedures you have hand and times you have been hospitalized and any other scars you may have:_____

_____

_____

What do you hope to get from your vist/treatment (select all that apply)

O Reduce your symptoms O Explanation of condition/treatment O How to prevent this from occurring again

O Resume/Increase activity O Learn how to take care of this on my own O (other)_____

Patient Signature_____ **Date**_____