LaserTech Pain Relief Centers – New Patient Information

Name: ____ **Sex:** **M / F** **Date:** ______________

Full Address: ____

____

____

Home Phone #: ________________________________ **Cell Phone #:**________________________________

Social Security #: ________________________________

Date of Birth: ________________________________ **Email:** ____________________________________

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Females; Are you pregnant?				
Sleeping posture ☐ side ☐stomach ☐back				

Is there a family history of: Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other __________________

Present Complaint:
____

Is condition getting progressively worse?
____

Have you seen any other Doctors seen for this condition?
____

What other treatments have you tried? Please list them and their effectiveness
____
____

Have you experienced any side effects from the drugs and surgeries?
____

Other Symptoms:

☐	Headaches	☐	Pins and Needles in legs	☐	Fainting
☐	Neck Pain	☐	Pins and Needles in Arms	☐	Loss of Smell
☐	Sleeping Problems	☐	Numbness in Fingers	☐	Loss of Taste
☐	Back Pain	☐	Numbness in Toes	☐	Diarrhea
☐	Nervousness	☐	Shortness of Breath	☐	Feet Cold
☐	Tension	☐	Fatigue	☐	Hands Cold
☐	Irritability	☐	Depression	☐	Stomach Upset
☐	Chest Pains	☐	Lights Bothers Eyes	☐	Constipation
☐	Dizziness	☐	Loss of Memory	☐	Cold Sweats
☐	Face Flushed	☐	Ears Ring	☐	Loss of Balance
☐	Neck Stiff	☐	Fever	☐	Buzzing in Ears

Patient History

1. What is your **main complaint**? ______________________________
2. On the scale below, please circle the **severity** of your **main complaint** (At it's worst)

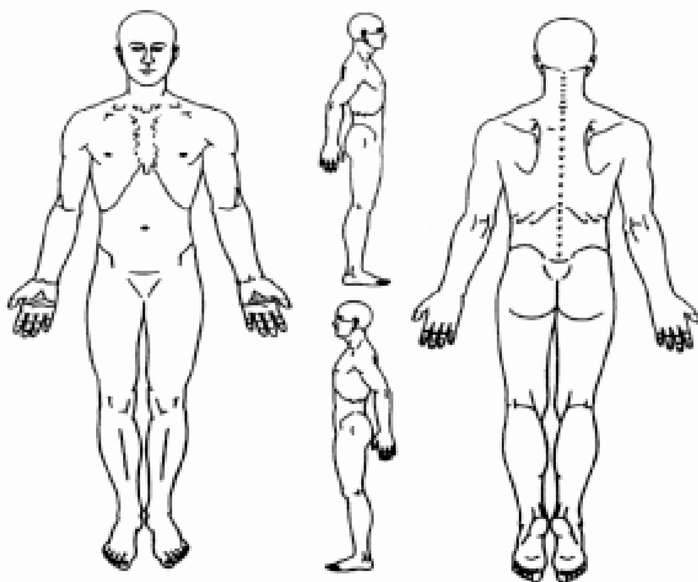
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle the **percentage of time** you experience your **main complaint:**

		Occasional			*Intermittent*			*Frequent*		*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _________
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature: ________________

Date: ____/____/____

6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? ______________________________
8. What makes it feel worse? ______________________________
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates? ____________ to ____________
12. Are you pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? ____________
14. Number of pregnancies? _________ Miscarriages? ____________

Employment Information

Business Name: ___________________________________ **Occupation/Job Title: ___________________**
Business Address: _________________________________ **Name of Supervisor:_____________________**

Business Phone: (___________)__________-___________ **Type of Work:______________________________**

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) Myself ONLY

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific):_______________

Personal Health Insurance Carrier: __________________ **Health ID Card #: ___________________________**

Policy Holder's Name: _____________________________ **Group #: ___________________________________**

Policy Holder's Social Security #: ______-_____-_______ **Primary Care Physician: _______________________**

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date:___/___/_____Time: _____am/pm

Carrier: ____ **Policy # ________________________________**

Carriers Phone #: (_______) ___________-_______________ **Adjuster: ________________________________**

Claim #: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _________________________ Patient's Signature: ______________________ Date: _________

Consent to treat a Minor: ____________________________ Date: ___________

Guardian or Spouse's Signature of Authorizing Care: ____________________________________ Date: _______________

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Please List your Primary Care Physician
Doctor: ____
City, State: _____________________________________
Phone #: _______________________________________