PATIENT INFORMATION SHEET

Name: _____ **Sex: M / F** **Date:** _____

Full Address: _____

_____

_____

Home Phone #: _____ **Cell Phone #:** _____

Date of Birth: _____ **Email #:** _____

Current Health	Yes	No	Patient Comments	Doctor Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Surgeries w/ **Metal or Hardware**?				
Have you been in accidents?				
Heart Problems; **Pacemake**r / **Defibrillator**				
Allergies? **Shellfish**/ Other?				
History Of **Cancer**? Chemotherapy?				
Females; Are you pregnant?				
Diabetes?				
Abdominal Aneurism?				

Do you have a family history of: oHeart Disease oArthritis o Cancer o Diabetes o Other _____

Current Medications: o Steroids o Pain Relievers o Beta Blockers o Blood Thinners o Gabapentin / Neurotin / Lyrica/ Other: _____ o Statin Drugs o Other _____

Present Complaint: _____

How long have you been experiencing your main complaint? _____

What activities aggravate your condition/pain _____

What activities lessen your condition/pain _____

Is condition worse during certain times of the day? _____

Do you have PAIN or DIFFICULTY performing any of the following activities: *Work ____Sleep ____Daily Routine/ Personal Care____ Walking____ Sitting____ Standing____ Recreation ____ Lifting____ Other ____*

Is condition getting progressively worse? _____

Have you seen any other Doctors for this condition? _____

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

If you experience/ or have experienced any of the following symptoms, please check the box to the left;

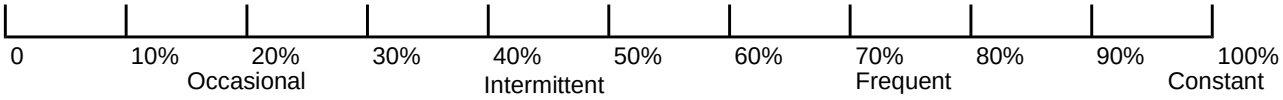
o	Headaches	o	Pins and Needles in legs	o	Fainting
o	Neck Pain	o	Pins and Needles in Arms	o	Loss of Smell
o	Sleeping Problems	o	Numbness in Fingers	o	Loss of Taste
o	Back Pain	o	Numbness in Toes	o	Diarrhea
o	Nervousness	o	Shortness of Breath	o	Feet Cold
o	Tension	o	Fatigue	o	Hands Cold
o	Irritability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

LaserTech Pain Relief Center
8550 East Shea Blvd. #110
Scottsdale, AZ 85260
480-222-4228
Dr Craig Zimmerman, Chiropractic Physician

PATIENT NAME:_____

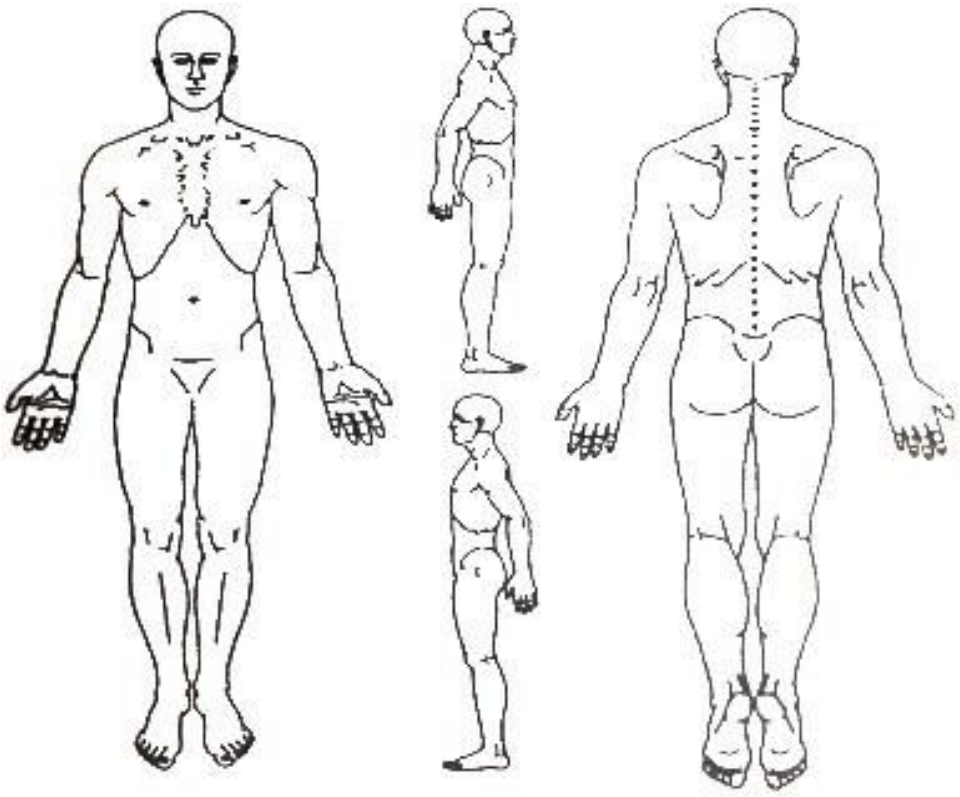
1. On the scale below, please **circle** the **SEVERITY** of your **main complaint** (at its worst)**:**

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



3. On the diagram below, please indicate **where** you are experiencing **all** your present complaints by using the following letters:

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



Employment Information

Business Name: _____ **Occupation/Job Title:**_____
Business Address: _____ **Type of Work:** _____
City_____ **State**_____ **Zip**_____ **Business Phone:( )**____-_____

Insurance Information

Who is responsible for your bill? You and…. (Please, check appropriate box (s)
Myself Only Spouse Worker's Comp Auto Insurance Medicare
Personal Health Insurance Carrier: _____ **ID #**_____
Holder's name: _____ **Group #**_____
Policy Holder's Social Security #_____-_____-_____

Workers Compensation Injury/ Auto/ Personal Injury

Have you filed and injury report with your employer? Yes/ No Date__/__/_____
Claim #_____
Carrier: _____ **Policy #**_____
Carrier's Phone # (___**)**____-____ **Adjuster:**_____

I understand and agree that health /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 directly 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. It is understood and agreed the amount paid the Doctor, for x-rays, is for the 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 the patient is in this office. As the patient, I also agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I give authority for these procedures to be performed.

Patient Print Name: _____ **Date:** _____/_____/_____
Patient signature authorizing care: _____

Guardian or Spouse's signature authorizing care:_____
Relationship to patient: _____

I acknowledge that I have received the Clinic's Notice and Privacy and Practices for protected health information:
Patient Signature: _____ **Date:** ____/___/_____