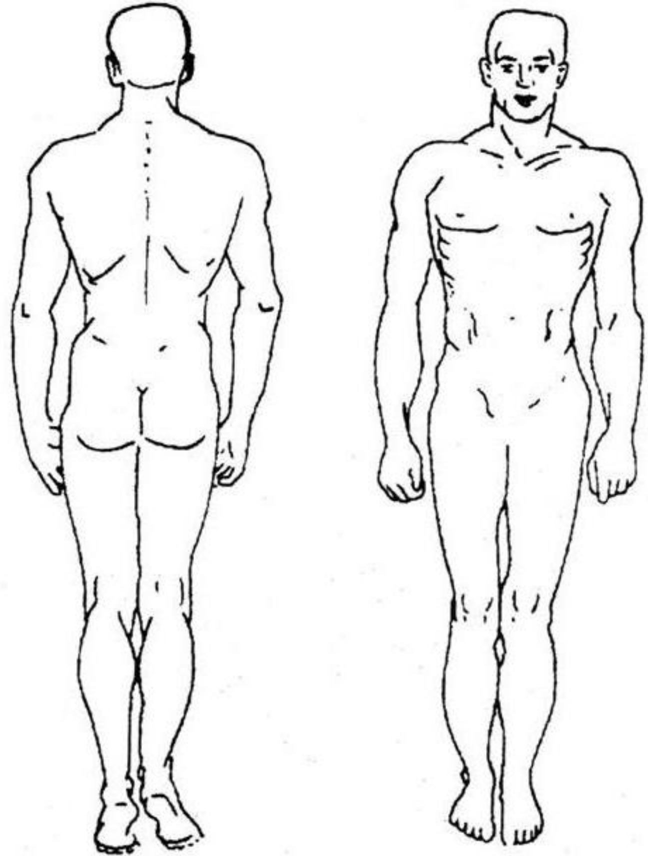
APPLICATION FOR ADMISSION

Physicians Wellness Care, Inc.

Patient Full Name:		Today's Date:
Date of Birth:	Email Address:	Sex: ☐Male ☐Female
Address:		
City:	State:	Zip Code:
Home Phone Number:	Work Phone Number:	Cell Phone Number:
Out of State Phone:	Out of State Address:	
Employer Name & Address:	Occupation:	Employer's Phone::
Marital Status: ☐Single ☐Widowed ☐Married ☐Divorced	Spouse's Name: Spouse's Employer:	Social Security Number:
	Emergency Contact Name:	Emergency Contact No.:

How did you hear about our office:	
How serious do you think your problem is:	
What is your main health concern/symptom prompting your request for a consultation with the doctor?	
Would you consider this concern:	☐ Minimal (Annoying but causing NO limitations) ☐ Slight (Tolerable but causing a little limitations) ☐ Moderate (Sometimes tolerable but definitely causing limitations) ☐ Severe (Causing significant limitations) ☐ Extreme (Causing near constant limitations. Over 80% of the time.)
In spite of the fact that you are not a doctor, you are in fact the person you know more about your health than anyone else. In your own words/opinion, what do you think the real problem is?	
What are you hoping happens today as a result of your consultation with the doctor?	
Since your pain became this severe what are some of the things you can no longer do and miss in your life?	
How has your life changed since you began having problems?	
How long have you been in this situation? Years _____________ Months _____________	When is the VERY FIRST time you can recall having this problem?

©USSpineCare.com LLC 2009

Are you under the care of any other doctor? ☐ Yes ☐ No	 ____ ____ ____ ____ ____ ____ ____
If so, the condition(s) being treated for:	
Describe any health problems, including how long you've had them:	
Name of Primary Care Physician:	
List of all current Medications:	
List any past surgeries & dates:	
List any past accidents & dates:	
List any x-ray or MRI's you've had in the past 2 years:	**FEMALES ONLY**: Is there a possibility of you being pregnant? ☐ Yes ☐ No
What activities are you limited in?	

©USSpineCare.com LLC 2009

What kind of treatment have you tried in the past:	☐Epidural ☐Physical Therapy ☐Medication ☐Surgery ☐Chiropractic	How Many ___________________ How Long ___________________ ___________________________ Type ______________________ ___________________________	When (Appx.) _______ When (Appx.) _______ When (Appx.) _______ When (Appx.) _______ When (Appx.) _______

Did any past treatments help? If so, which one and for how long?

If there anything you can do that gives you temporary relief?

What activities/movements make your pain worse?

Describe the type of pain. *(Is is sharp, dull, achy, shooting, stabbing, numb, tingling, etc.?)*

What time of day is the pain most severe?	☐Morning ☐Afternoon ☐Evening	Does the pain worsen as the day progresses?	☐Yes ☐No

List in order of importance ALL other health problems and/or concerns not including the MAIN PROBLEM listed above for your visit today:

1. ____ How long have you had this problem? ___________
2. ____ How long have you had this problem? ___________
3. ____ How long have you had this problem? ___________
4. ____ How long have you had this problem? ___________
5. ____ How long have you had this problem? ___________

In reference to your visit today, how often do you experience this problem:	☐ Occasionally (0 – 25% of the time) ☐ Intermittently (26 – 50% if the time) ☐ Frequently (51 – 75% of the time) ☐ Constantly (76 – 100% of the time)

On a Scale of 0 to 10 (0 being No Pain or Discomfort and 10 being Unbearable Pain and Discomfort), Please Rate the Following:	The HIGHEST your pain gets WITHOUT medication _________ The LOWEST your pain gets WITHOUT medication _________ The HIGHEST your pain gets WITH medication ____________ The LOWEST your pain gets WITH medication _____________

©USSpineCare.com LLC 2009

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 12 MONTHS:
MARK "**C**" FOR **CURRENTLY EXPERIENCING**. MARK "**X**" FOR **HAVE EXPERIENCED IN THE LAST 12 MONTHS**.

GENERAL:

Chills ________
Convulsions ________
Dizziness ________
Fainting ________
Fever ________
Headache ________
Loss of Sleep ________
Allergy (to_________) ________
Loss of Weight ________
Nervousness ________
Wheezing ________
Bronchitis ________
Numbness in Hands ________
Numbness in Feet ________
Weakness ________
Fatigue ________

EARS/EYES/NOSE/THROAT:

Asthma ________
Crossed Eyes ________
Double Vision ________
Blurred Vision ________
Difficulty Swallowing ________
Deafness ________
Hearing Loss ________
Ear Pain ________
Thyroid Problem ________
Nose Bleeds ________
Sinus Problems ________
Sore Throat ________

GASTRO-INTESTINAL:

Gas ________
Colon Trouble ________
Constipation ________
Diarrhea ________
Gallbladder Trouble ________
Hemorrhoids ________
Liver Trouble ________
Nausea ________
Stomach Ache ________
Poor Appetite ________
Poor Digestion ________
Vomiting ________
Vomiting Blood ________
Rectal Bleeding ________
Bloating ________

RESPIRATORY:

Chest Pain ________
Chronic Cough ________
Difficulty Breathing ________
Coughing/Spitting Blood ________

CARDIOVASCULAR:

High Blood Pressure ________
Low Blood Pressure ________
Pain Over Heart ________
Poor Circulation ________
Rapid Heartbeat ________
Heart Problems* ________
Slow Heartbeat ________
Stroke ________
TIA ________
Swollen Ankles ________
Varicose Veins ________
Aortic Aneurysm ________
Bruise Easily ________

*Describe any heart problems:

____

____

NEUROMUSCULOSKELETAL

Back Pain ________
Neck Pain/Stiffness ________
Foot Trouble ________
Pain Between Shoulders ________
Painful Tailbone ________
Stiff Neck ________
Spinal Curvature ________
Migraines/Headaches ________
Arm/Hand Pain ________
Knee Pain ________
Swollen Joints ________
Disc Condition ________
Leg/Foot Pain ________
Arthritis ________

GENITO-URINARY:

Blood in Urine ________
Frequent Urination ________
Inability to Control Urine ________
Kidney Infection ________
Painful Urination ________
Prostate Trouble ________
Painful Urination ________

NEUROLOGIC:

Seizures ________
Dizziness ________
Hand Trembling ________
Weakness ________
Difficulty With Speech ________
Loss of Memory ________
Loss of Coordination ________

DISEASES/CONDITIONS:

Appendicitis ________
Anemia ________
Arthritis ________
Alcoholism ________
Abdominal Surgery ________
Bleeding Disorder ________
Blood Clot(s) ________
Breathing Difficulty ________
Cancer ________
Colon Problems ________
Diabetes ________
Depression ________
Epilepsy ________
Eczema ________
Eating Disorder ________
Glaucoma ________
High Cholesterol ________
HIV + ________
Heart Disease ________
Hernia ________
Headaches ________
Influenza ________
Kidney Disease ________
Liver Disease ________
Lower Back Pain ________
Mental Illness ________
Measles ________
Mumps ________
Pleurisy ________
Pneumonia ________
Polio ________
Prostate Problems ________
Hyperthyroid ________
Rectal Surgery ________
Osteoporosis ________
Skin Conditions ________
Other ________

FOR MEN ONLY:

Lump in Testicles ________
Penis Discharge ________

FOR WOMEN ONLY:

Menstrual Cramps ________
Excessive Menstrual Flow ________
Hot Flashes ________
Irregular Cycle ________
Painful Periods ________
Birth Control Pills ________
Abnormal Pap Smear ________

©USSpineCare.com LLC 2009

©USSpineCare.com LLC 2009