

PATIENT INFORMATION

DATE: _____ HOME PHONE: _____ CELL: _____

FULL NAME: _____ SOC SEC NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____

SEX: () M () F DATE OF BIRTH: ___/___/___/ AGE: _____ () SINGLE () MARRIED () WIDOWED () SEPARATED () DIVORCED

PATIENT EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ PHONE NO: _____

EMERGENCY CONTACT: _____ PHONE NO: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NO: _____ PHARMACY: _____

PRIMARY INSURANCE

INSURANCE CO: _____ PHONE NO: _____

GROUP NO: _____ PHONE NO: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PERSON RESPONSIBLE: _____ SOC SEC NO: _____

RELATION TO PATIENT () SPOUSE () PARENT () LEGAL GUARDIAN () SIGNIFICANT OTHER DATE OF BIRTH: _____

RESPONSIBLE PARTY EMPLOYER: _____ PHONE NO: _____

IF YOU WERE INJURED, WAS INJURY CAUSED BY () WORK INJURY () MOTOR VEHICLE ACCIDENT () OTHER _____

ADDITIONAL INSURANCE

INSURANCE CO: _____ PHONE NO: _____

GROUP NO: _____ PHONE NO: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PERSON RESPONSIBLE: _____ SOC SEC NO: _____

RELATION TO PATIENT () SPOUSE () PARENT () LEGAL GUARDIAN () SIGNIFICANT OTHER DATE OF BIRTH: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ Insurance Company and assign all benefits to Panacea Brain and Spine, if any, for all service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the named medical group to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Responsible Party Signature Relationship to Patient Date

PATIENT NAME: _____ **DOB:** _____

Date: _____ What brings you into our office today? _____

What part of the body are we seeing you for today? (NOTE: we only see you for one condition at a time)

CIRCLE ONE neck back brain DCS shunt other: _____

Where is the pain located? Right Side Left Side Both Sides

Is your pain due to a:

Motor vehicle accident Work accident Fall Surgery Unknown

Describe your pain:

Throbbing Stabbing Burning Pins & needles Numbness Tingling

Does your pain radiate to any other part of your body?

Arms: Right shoulder/elbow/forearm/hand/fingers

Legs: Right buttocks/thigh/foot/toes

Left shoulder/elbow/forearm/hand/fingers

Left buttocks/thigh/foot/toes

What makes your pain *BETTER*?

Sitting Standing Walking Lying down Ice Heat Pain medications

Nothing helps other: _____

What makes your pain *WORSE*?

Sitting Standing Walking Lying down Lifting Pushing/pulling

Other: _____

Have you had? P.T. _____ Injections _____ Do Home Exercise Program _____

Rate your pain scale *MOST OF THE TIME*: (1 - little to no pain, 10 – worst pain you have ever felt)

0 1 2 3 4 5 6 7 8 9 10

Please give a **CLEAR** description of what occurred to cause this pain and/or injury for what we are seeing you for today. We will be evaluating **ONLY ONE** specific area per office visit. If you have more issues that you would like to be seen for, please make an additional appointment and we will be glad to see you.

***If you did not have an accident, fall, or trauma to cause your pain,
please add a time frame when this pain occurred***

HOW did this pain/injury happen?

WHAT happened to cause the pain/injury?

WHEN/DATE did the pain/injury/accident happen?

Any additional information:

Please list your **CURRENT MEDICATIONS, INCLUDING OVER-THE-COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS**, which you are taking. Fill in the start date to the best of your knowledge. If you did not bring in your list of medications, please make sure you bring it to your next appointment. **THIS IS VERY IMPORTANT!**

MEDICATION	DOSE	HOW OFTEN	REASON	START DATE

Who is your Pain Management Doctor? _____

Are you taking any *blood thinners*? Yes No If yes, what medication? _____

Why are you taking this medication? _____

Do you have an allergy to *contrast dye*? Yes No

Do you have an allergy to *latex*? Yes No *Adhesives*? Yes No

Do you have any allergies to *medications*? Yes No

If yes, please list the medications and reaction.

Medication	Reaction

Please circle your **MEDICAL HISTORY**. If yes, please name the doctor that you are **CURRENTLY** seeing for this condition.

Do you HAVE or HAVE YOU EVER had any of the following:

Aneurysm _____

Anxiety disorder _____

Asthma _____

Back problems _____

Arthritis _____

Bleeding disorder _____

COPD _____

Chronic Pain _____

Cancer _____ Type _____

Coronary artery disease _____

Depression _____

Fibromyalgia _____

Frequent cough _____

Head trauma/injury _____

Headaches _____

Heart attack MI _____

Heart problems/surgery _____

Diabetes _____ Type _____

Hepatitis _____

Hypertension _____

Hypothyroidism _____

Kidney disease _____

Liver disease _____

Lupus _____

Migraines _____

MRSA _____

Multiple sclerosis _____

Neck injury _____

Osteoporosis _____

Bone Density Test/DEXA Date _____

Seizures/Epilepsy _____

Sleep disorder _____

Stroke _____

Thyroid problems _____

Ulcers _____

UTI _____

Other: _____

All past surgeries:

Date:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Does your **MOTHER** or **FATHER**(*not you*), have any of the following medical conditions:

High blood pressure:	Mother	Father
Heart disease:	Mother	Father
Cancer:	Mother	Father
Diabetes:	Mother	Father
Asthma:	Mother	Father
Depression:	Mother	Father
Dementia:	Mother	Father
Unknown		

Any other **SERIOUS** medical conditions: _____

Do you do any of the following?

Drink alcohol:	Yes	No	Drinks per week: _____
Recreational Drugs:	Yes	No	Type: _____
Do you smoke:	Yes	No	Packs per day: _____
Former smoker:	Yes	No	When did you quit: _____
Drink caffeine:	Yes	No	Drinks per day: _____

Marital Status: Married Single Separated Divorced Widowed

What is your current working status? Retired disabled medical leave

Are you currently working? Yes No If yes, where: _____

If on medical leave, when did your leave start? _____

Do you have an Advanced Directive? Yes No

Please circle **YES** or **NO** to any of the following symptoms that you are **CURRENTLY** having.

General:

Weakness	Y	N	Difficulty sleeping	Y	N
Tiredness	Y	N	Fever	Y	N
Lack of appetite	Y	N	Weight gain/loss (circle one)		

Cardiovascular:

Chest pain/tightness/squeezing	Y	N	Discoloration of hands/feet	Y	N
Shortness of breath lying down	Y	N	Leg pain with exertion	Y	N
Need to sit up to breathe	Y	N	Leg pain at rest	Y	N
Heart racing	Y	N	Swelling of legs	Y	N
Irregular heartbeat	Y	N	Heart murmur	Y	N

Gastrointestinal:

Nausea	Y	N	Vomiting	Y	N
Need for antacids	Y	N	Constipation	Y	N
Heartburn	Y	N	Abdominal pain	Y	N
Bright red blood in stool	Y	N	Black stool	Y	N
Change in bowel habits	Y	N			

Ears, eyes, nose, throat:

Blurred vision	Y	N	Eye Pain	Y	N
Ringing in ears	Y	N	Hoarseness	Y	N

Respiratory:

Cough	Y	N	Wheezing	Y	N
Shortness of breath	Y	N	Chest pain w/ cough	Y	N

Endocrine:

Heat or cold intolerance (circle one)			Hand trembling	Y	N
Change in voice pitch	Y	N			

Urinary:

UTI	Y	N	Pain/burning urination	Y	N
Stress incontinence	Y	N	Frequent urination	Y	N
Urgency incontinence	Y	N	Inability to control	Y	N

Neurological:

Seizures	Y	N	Headaches	Y	N
Blackouts	Y	N	Dizziness	Y	N
Paralysis/weakness	Y	N	Loss of sensation	Y	N
Loss of balance	Y	N	Loss of coordination	Y	N
Speech problems	Y	N			

Skin:

Itching	Y	N	Change in skin color	Y	N
Change in skin temp	Y	N	Falling or of hair	Y	N
Nail changes	Y	N	Skin ulcers	Y	N

Musculoskeletal:

Muscle pain	Y	N	Neck/back pain	Y	N
Right shoulder pain	Y	N	Left shoulder pain	Y	N
Right leg pain	Y	N	Left leg pain	Y	N
Joint pain	Y	N	Joint redness	Y	N
Joint stiffness	Y	N			

Psychiatric:

Nervousness	Y	N	Early morning awakening	Y	N
Depression	Y	N			
Problems with memory of past events	Y	N			
Problems with memory of recent events	Y	N			
Difficulty thinking with problem solving	Y	N			

PLEASE MAKE SURE ALL SECTIONS ARE COMPLETE BEFORE HANDING IN. THANK YOU.

5/18/26