SKANEATELES
SPINE AND SPORT

PATIENT INFORMATION			EMAIL ADDRESS:	
First Name:	Last Name:		Middle Initial:	Date: / /
Address:	City:		State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	☐ Married ☐ Single ☐ Other	S.S. #: - -
Home Phone: ( ) -	Cell Phone ( ) -		Spouse's Name:	

WORK INFORMATION			
Employer:	Work Phone ( )	Occupation:	
Employer Address:	City	State:	Zip:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Full-time Student ☐ Part-time Student

REFERRAL/PHYSICIAN INFORMATION

Chose clinic because: ☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Insurance Plan ☐ Family/Friend

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

Insurance Name: ☐ Auto :		☐ Labor & Industries:	
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Skaneateles Spine & Sport. I understand that I am financially responsible for any balance. I also authorize Skaneateles Spine & Sport to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
Fainting	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE/TENDON CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Golfer's/Tennis Elbow R/L	☐	☐
Back/Neck	☐	☐
Hip/Knee/Ankle	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Arthritis	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
CANCER (previous or currently)	☐	☐

Other: _____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

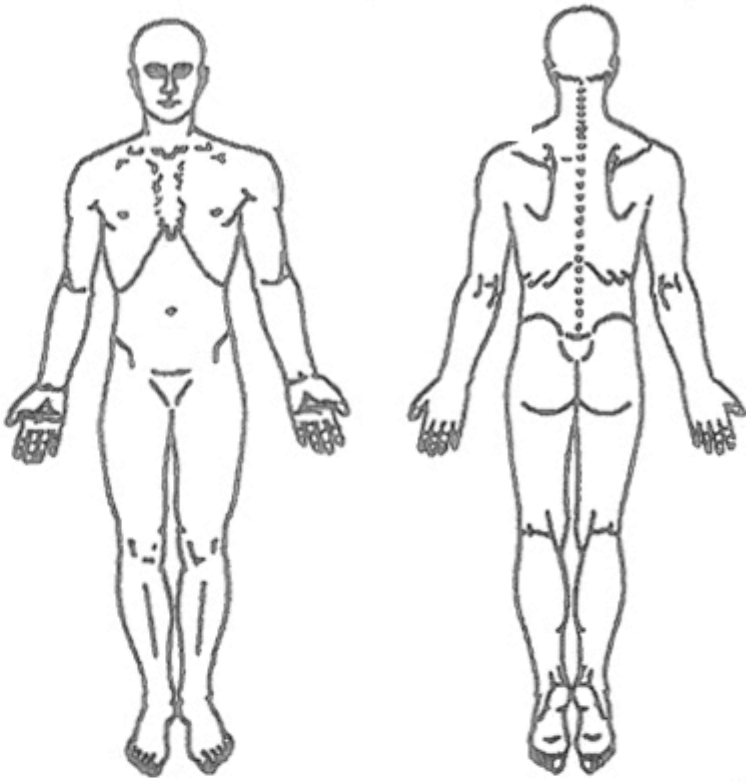
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / /	x x x x
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____