

Today's Date (month/day/year): ____/____/____
Z#: _____

PATIENT RE-EVALUATION FORM

CONTACT INFORMATION:

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____)____-____ Cell #: (____)____-____ Work Phone #: (____)____-____

Contact Preference: _____ Do you want text reminders for your appointments? _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Ph: (____)____-____

Do we have permission to discuss scheduling/appointments with emergency contact? Yes or No

Do we have permission to discuss financial amount owed or credit with emergency contact? Yes or No

PRIMARY CARE PHYSICIAN:

First Name: _____ Last Name: _____ Group: _____

Doctor's Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION: *(If your insurance has changed since your last visit please present your benefit card to the front desk staff with this completed form)*

PATIENT HISTORY & CONSULTATION:

Describe the health concern you are experiencing: _____

How long have you been suffering with this? _____

What do you think caused your health complaint? _____

Is this health concern related to a worker's compensation injury or a No Fault injury (car accident): Yes or No

If yes, what was the injury and when? _____

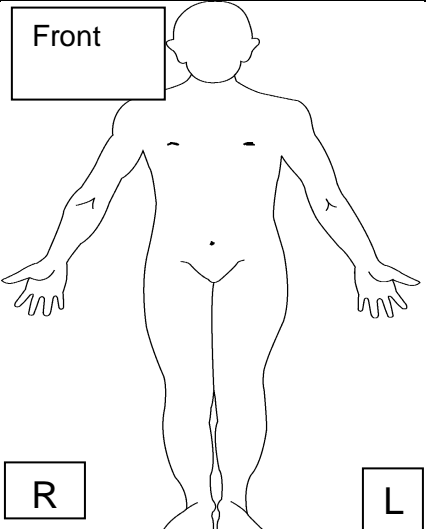
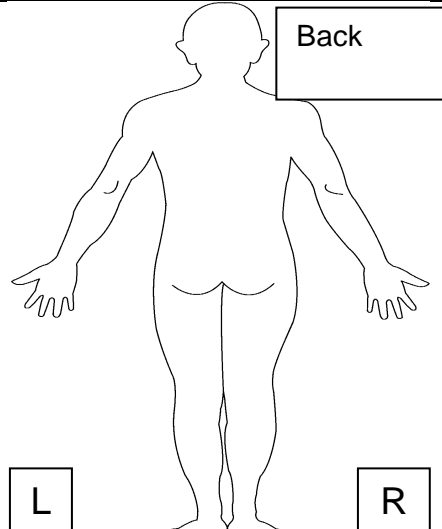
Have you ever experienced this before? _____

What makes your problem worse? _____

Does anything improve your problem? _____

Have you had any diagnostic tests performed for this complaint? (circle one) X-rays CT Scan MRI Nerve Testing (EMG) Other

PATIENT DIAGRAM: (Please circle the area(s) that are bothersome and show any radiation of pain/symptoms with an arrow)

<p>Front</p>  <p>R L</p>	<p>Back</p>  <p>L R</p>	<p>Rate the severity of your condition by circling a number below [Zero equals none/Ten is severe].</p> <p>Neck Region:</p> <p>(_____) 0 1 2 3 4 5 6 7 8 9 10 no pain severe pain</p> <p>Mid-Back Region:</p> <p>(_____) 0 1 2 3 4 5 6 7 8 9 10 no pain severe pain</p> <p>Lower Back and Leg Region:</p> <p>(_____) 0 1 2 3 4 5 6 7 8 9 10 no pain severe pain</p>
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I have been provided a copy of the terms of acceptance, consent to use and disclosure of protected Health Information, as well as appointment policies for this office.

Patient Signature: _____ Today's date: _____