

HEAD NECK & SPINE CENTER OF SAN DIEGO



INITIAL HEALTH STATUS

PATIENT NAME: _____ BIRTHDATE: _____ SEX: M/F
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 SOCIAL SECURITY #: _____ DRIVER LICENSE # _____
 OCCUPATION: _____ EMPLOYER: _____ ADDRESS: _____ C,S,Z: _____
 TELEPHONE: _____ WORK PHONE: _____ CELL: _____
 EMAIL ADDRESS: _____ HEALTH PLAN: _____
 SUBSCRIBER NAME: _____ SUBSCRIBER ID #: _____ GROUP #: _____
 SPOUSE NAME: _____ SPOUSE EMPLOYER: _____ C,S,Z: _____

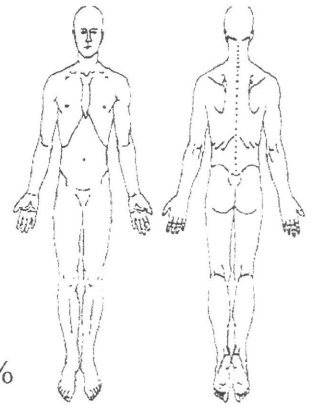
MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is This? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____

Current Complaint (How You Feel Today):											
0	1	2	3	4	5	6	7	8	9	10	
No Pain											Unbearable Pain



How often are your symptoms present? 0-25% 26-50% 51-75% 75-100%

Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? NO YES **Date(s) Taken:** _____

What Areas Were Taken? _____

Please check all of the following that apply to you: None Apply

No	Yes	Condition	No	Yes	Condition
<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, #of Births _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> G <input type="checkbox"/> L
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	History of Low/Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date) _____	<input type="checkbox"/>	<input type="checkbox"/>	History of Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries/Medications:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			
<input type="checkbox"/>	<input type="checkbox"/>	Recent Trauma			

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____

Date: _____