



Advanced Health Solutions

Georgia Spine and Disc

APPLICATION FOR CARE

Today's Date: _____ *Whom may we thank for referring you to this office? _____

Dear Patient, This information is considered confidential. We need this information because we care enough to want to know the underline cause of your health challenges. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please answer all questions completely.

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Social Security #: _____ E-mail Address: _____
 Home Phone: _____ Mobile Phone: _____ Work phone: _____
 Marital Status: Single Married Divorced Widowed
 Do you have Insurance: Yes No
 Type of insurance: BC/BS Aetna Cigna UHC Coventry Humana Medicare
 Employer: _____ Occupation: _____
 Number of children and Ages: _____
 Name & Number of Emergency Contact: _____ Relationship: _____

CHIEF COMPLAINT & HPI

Please identify the condition(s) that brought you to this office: Primarily: _____
 Secondarily: _____ Third: _____ Fourth: _____

Rate your pain for each complaint, on a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate you're above complaints by circling the number:

Primary or chief complaint:	0	1	2	3	4	5	6	7	8	9	10
Second complaint:	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint:	0	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____
 When is the problem at its worst? AM PM mid-day late PM
 Frequency of Main Problem/Pain? Constant Frequent Intermittent
 How did the pain start? _____
 Have you seen any doctor(s) for this condition? No Yes If yes, when: _____
 by whom? _____
 How long were you under care: _____ What were the results? _____

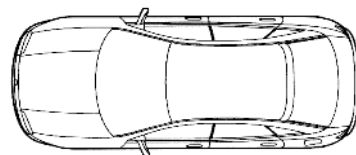
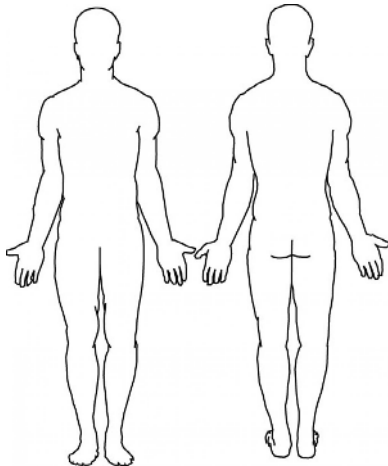
***PLEASE MARK the areas on the Diagram** with the following letters to describe your symptoms:

T= Tingling N = Numbness S = Sharp/ Stabbing R = Radiating
 B = Burning D = Dull A = Aching

What relieves your symptoms? _____
 What makes them feel worse? _____

Is your problem the result of ANY type of accident? No Yes

If yes, what kind of accident: MVA W.C PI Date: _____



Mark X on the diagram.

Patient's Name: _____

Date: _____

ACCIDENT HISTORY: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Reading/Concentration	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Shaving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Yard work	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuuming	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dishes	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Laundry	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other _____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

MEDICATIONS

Please list the dose and frequency of ALL medications you are currently taking (including Aspirin, Allergy Medication, Birth Control Pills, Vitamins, etc.):

MEDICAL HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes

If yes how many times? _____ When was the last episode? _____

Please list any medical condition that you think you have or been diagnosed with:

ALLERGIES

Please list any allergies or intolerance to medications, iodine, or other materials:

SURGICAL HISTORY

Please list any operations you had in the past 10 years:

HOSPITALIZATION

Please list any reason for hospitalization in the past 5 years:

Patient's Name: _____

Date: _____

FAMILY HISTORY:

Member	Age	Diabetes	Hypertension	Heart Dx	Stroke	Cancer	Other
Father							
Mother							
Grandfather							
Grandmother							

SOCIAL HISTORY

Do you smoke? If yes, how much and how often? _____

Do you drink ALCOHOL? If yes, how much per day? _____

Do you use DRUGS? If yes, what kind of drugs and how much do you use per day? _____

REVIEW OF SYSTEMS (ROS)

Do you have a history of any of the following? Check any that apply:

- Diabetes: _____
- Heart Disease: _____
- High Blood Pressure: _____
- Stroke: _____
- Cancer: _____
- Skin Diseases (i.e... Psoriasis, etc.): _____
- Lung Disease: _____
- Stomach Problems: _____
- GI problems: _____
- Eye Disease: _____
- Nose or Throat Problems: _____
- Psychiatric Problems (i.e... Depression, etc.): _____
- Circulatory Problems: _____
- Infectious Disease Problems (i.e... AIDS, Pneumonia, Tuberculosis, etc.): _____
- Neurological Problems (i.e... Multiple Sclerosis, Diabetic Neuropathy, etc.): _____
- Kidney or Bladder Problems: _____
- Joint Problems (i.e... Arthritis, Bursitis, etc.): _____

NEUROLOGICAL / VASCULAR HISTORY

Do you suffer from shoulder, arms or hands pain, tingling/ numbness or weakness? If yes, how often? Yes No

Do you suffer from cold hands or feet ? Yes No

Do you suffer from loss of hand grip strength? Yes No

Do you suffer from tingling, numbness or weakness in your legs or feet? Yes No

Do you suffer from frequent headaches? Yes No

Have you had an MRI? Yes No

If yes, who ordered it? When was it done? What Part of the Body was it ordered on?

Have you used any splints or braces prescribed by an MD? Yes No

If yes, When?, Who order it? What kind?

Patient signature: _____ Today's Date: ____ / ____ / ____