Advanced Health Solutions
Georgia Spine and Disc

APPLICATION FOR CARE

Name: _____ **Date of Appointment:** _____

Thank you for allowing us to help you. Whom may we thank for referring you to this office? _____

PERSONAL DEMOGRAPHICS

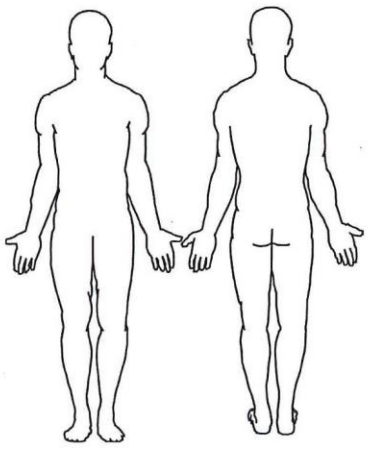
Birth Date: ____-____-____ Age: _____ ❑ Male ❑ Female
Address: _____ City: _____ State: ____ Zip: _____
Social Security No: _____ Email Address: _____
Cell Phone: _____ Work Phone: _____
May we leave you a voicemail and/or text message? ❑ Yes ❑ No
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Do you have Insurance: ❑ Yes ❑ No
Type of Insurance: ❑ BC/BS ❑ Aetna ❑ Cigna ❑ UHC ❑ Coventry ❑ Humana ❑ Medicare
Pharmacy Name: _____ Phone No: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

CHIEF COMPLAINT & HPI

Please identify the condition(s) that brought you to this office: First: _____
Second: _____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 your complaints above 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

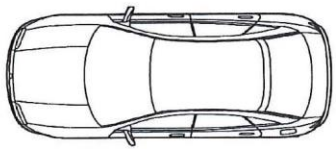
When did the problem(s) begin? _____
When is the problem at its worst? ❑ AM ❑ PM ❑ Mid-Day ❑ Late PM
Frequency of Main Problem/Pain? ❑ Constant ❑ Frequent ❑ Intermittent
How did the pain start? _____
Have you seen any doctor(s) for this condition? ❑ No ❑ Yes If yes, when? _____
By whom? _____
How long 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 ❑ WC ❑ PI Date: _____



Mark X on the diagram.

Notes: _____

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
Yardwork	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuming	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 have 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? ❑ Yes ❑ No If yes, how often?

_____

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 ordered it? What kind?

_____

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