

San Diego Spine & Rehab
858-259-0553

Patient Information Form

Date: _____ Pt. Number: _____

First Name _____ Last Name _____ Date of Birth ___/___/___

Address _____

City _____ State _____ Zip _____

Home Ph (____) _____ Work Ph (____) _____

Age _____ Email _____

Social Security # ____ - ____ - ____ Driver's License # _____

Sex: M / F Occupation _____ Employer _____

Work Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Phone # (____) _____

How were you referred to our office? _____

Do you have any type of health insurance coverage? Y / N Policy/Group # _____

Name of Insured _____ Social Security # ____ - ____ - ____

Insurance Company _____ Phone # (____) _____

Current Health Problems (Why are you here?):

1. _____ 2. _____

3. _____ 4. _____

Are any of these problems related to: ___ Work Injury / ___ Auto Accident / ___ Other

List any other doctors consulted for these problems: _____

Name _____ Phone # (____) _____

Name _____ Phone # (____) _____

I hereby authorize and assign to San Diego Spine & Rehab / Direct Health Medical Center and their doctors my rights to receive payments from negligent parties or from insurance companies. I authorize SDSR/DHMC to release any information to any insurance carrier, adjuster, attorney, or government agency that will assist in the payment for services rendered by SDSR/DHMC and its doctors. I understand that any x-rays taken by SDSR/DHMC are the property of this office and cannot be released directly to the patient.

Patient's Signature _____ Date _____

San Diego Spine & Rehab Inc.
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Name _____ PATIENT HISTORY Date _____

1. What seems to be the problem? What's the worst? _____

2. When did this start? _____

3. What did you do to hurt yourself? _____

4. Describe the pain. . . sharp, dull, burning, throbbing, etc. _____

5. Is it getting better or worse? _____
6. Is the pain constant or does it come and go? _____ If it comes and goes,
how often does it hurt? _____

7. Have you ever had this problem before? _____ When? _____
8. Do you have any pain in the shoulders, arms, or legs? Any tingling or numbness?
What is it? _____
9. Can you find a comfortable position which seems to relieve your symptoms? What
is it? _____
10. Have you done anything for this?
Heating pad? _____ Help? _____
Ice? _____ Help? _____
Aspirin, Advil, Tylenol? _____ Help? _____
Ben Gay, Deep Heat, Icy Hot? _____ Help? _____
11. What seems to aggravate this? _____

12. Have you ever seen a Medical Doctor about your back or this condition? If so,
what was the diagnosis? What was the treatment? Drugs? _____

13. Are you on Medication now? _____ What? _____ What for? _____

14. Have you ever had any surgery? _____ What? _____

15. Have you ever been to a chiropractor before? _____ When was the most recent
time? _____ What for? _____ What did he/she do? (treatment) _____

16. What do you do for a living or during the day? Activities? _____

17. Is this so bad you can't work? (Yes) or (No) _____
Does it slow you down at work? (Yes) or (No) _____
Does it keep you from doing anything that you want to do? _____
Does it keep you from sleeping? (Yes) or (No) _____
How does this affect you? _____