



BRENTWOOD

spine + sport

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Email: _____
 Social Security #: _____ Driver's Lic. #: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Subscriber Name: _____ Health Plan: _____
 Subscriber ID #: _____ Group #: _____ Spouse Name: _____
 Spouse Employer: _____ City: _____ State: _____ Zip: _____

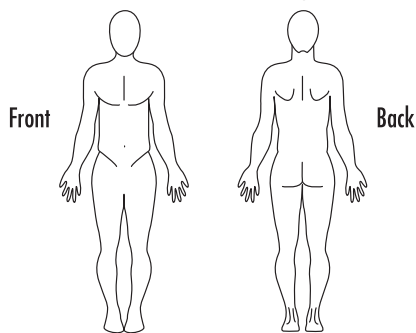
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

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					



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

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
 Can you perform your daily activities? Yes No Describe: _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? Yes No Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you:

None Apply

NO YES CONDITION

- History of Recent Infection
- Recent fever
- HIV / AIDS
- Diabetes
- Corticosteroid Use
- Birth Control Pills
- High Blood Pressure
- Stroke (Date)
- Dizziness / Fainting
- Numbness in Groin / Buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer / Tumor
- Osteoporosis
- Recent Trauma

NO YES CONDITION

- Prostate Problems
- Frequent Urination
- Pregnancy, # of births: _____
- Abnormal Weight Gain Loss
- Epilepsy / Seizures
- Visual Disturbances
- History of Low / Mid Back Pain
- History of Neck Pain
- Arthritis
- History of Alcohol Use
- History of Tobacco Use
- Surgeries / Medications: _____

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: _____