

PREMIER HEALTHCARE OF PLACERVILLE, INC.

PATIENT INFORMATION

Date _____

First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Hm Phone # _____ Cell Phone # _____ Employer's Phone # _____
SS# _____ DL # _____
Age _____ DOB ____/____/____ Sex _____ Marital Status M S W D Email Address _____
Occupation _____ Employer _____ # of Yrs Employed _____
Employer's Address _____ City _____ State _____ Zip _____
Spouse's Name _____ DOB ____/____/____ Employer _____
Referred By _____
Whom My We Contact In Case Of An Emergency _____ Phone # _____

INSURANCE INFORMATION (please supply copy of Insurance Card and ID)

Medicare Yes No Medi-Cal Yes No Other Insurance Co. _____
Insured Person's Name _____ Insured's Employer _____
Insured Person's DOB ____/____/____ Insured's SS# _____
ID # _____ Group # _____

PAST PATIENT HISTORY

Have You Ever Been Involved In:

(please indicate date(s) of injury, is case open or closed, is there a future award. For open awards, please give claim #'s)

Work Related Injury Yes No If Yes, Please Explain ____/____/____

Auto / Personal Injury Yes No If Yes, Please Explain ____/____/____

MEDICAL HISTORY

- AIDS/HIV Diabetes Multiples Sclerosis Tuberculosis Surgery(type & date)
Alcoholism Emphysema Rheumatoid Arthritis Typhoid Fever
Allergies Epilepsy Pacemaker Chicken Pox
Goiter Pleurisy Appendicitis Whooping Cough
Arteriosclerosis Heart Disease Pneumonia Polio Venereal Disease (type)
Hepatitis Asthma High Blood Pressure Measles
Herpes Cancer Ulcers Mumps Other (include date)
Gout Seizures Stroke Rheumatic Fever
Fibromyalgia Trauma At Birth Scarlet Fever
Shortness of Breath Stress

RADIOLOGY HISTORY

Have you had previous: X-Ray MRI CAT Scan Other No If Yes, Please Explain(give dates) _____

For Women Only

Date Of Last Period ____/____/____ Cramping Irregularity
Are You Pregnant: Yes No If Yes, Due Date: ____/____/____
Of Vaginal Births _____ # C-Section Births _____

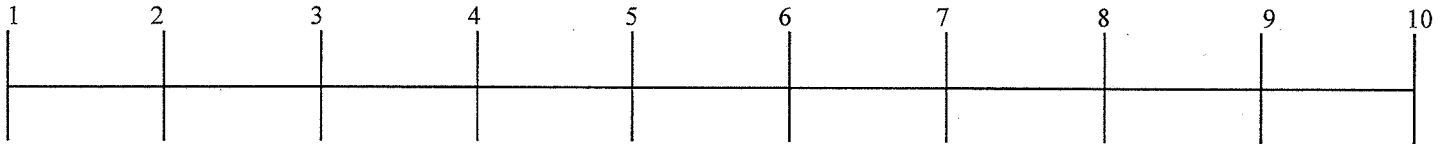
PRESENT SYMPTOMS / CHIEF COMPLAINTS (please circle areas affected and check appropriate box)

HEAD <input type="checkbox"/> headache <input type="checkbox"/> loss of memory <input type="checkbox"/> light headedness <input type="checkbox"/> dizziness <input type="checkbox"/> ringing in the ears	NECK <input type="checkbox"/> neck pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	MID BACK <input type="checkbox"/> mid back pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	LOW BACK <input type="checkbox"/> low back pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	GENERAL <input type="checkbox"/> nervousness <input type="checkbox"/> fatigue <input type="checkbox"/> depressed <input type="checkbox"/> irritable	CHEST <input type="checkbox"/> constipation <input type="checkbox"/> loss of sleep <input type="checkbox"/> loss of weight <input type="checkbox"/> shortness of breath
SHOULDER / ARM <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	ELBOW / FOREARM <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	WRIST / HAND / FINGERS <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	HIP / UPPER LEG <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> Pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	KNEE / LOWER LEG <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> pain <input type="checkbox"/> tightness <input type="checkbox"/> tenderness <input type="checkbox"/> numbness <input type="checkbox"/> muscle spasm	

Do You Have Any Radiating Pain Yes No If Yes, Please Explain _____

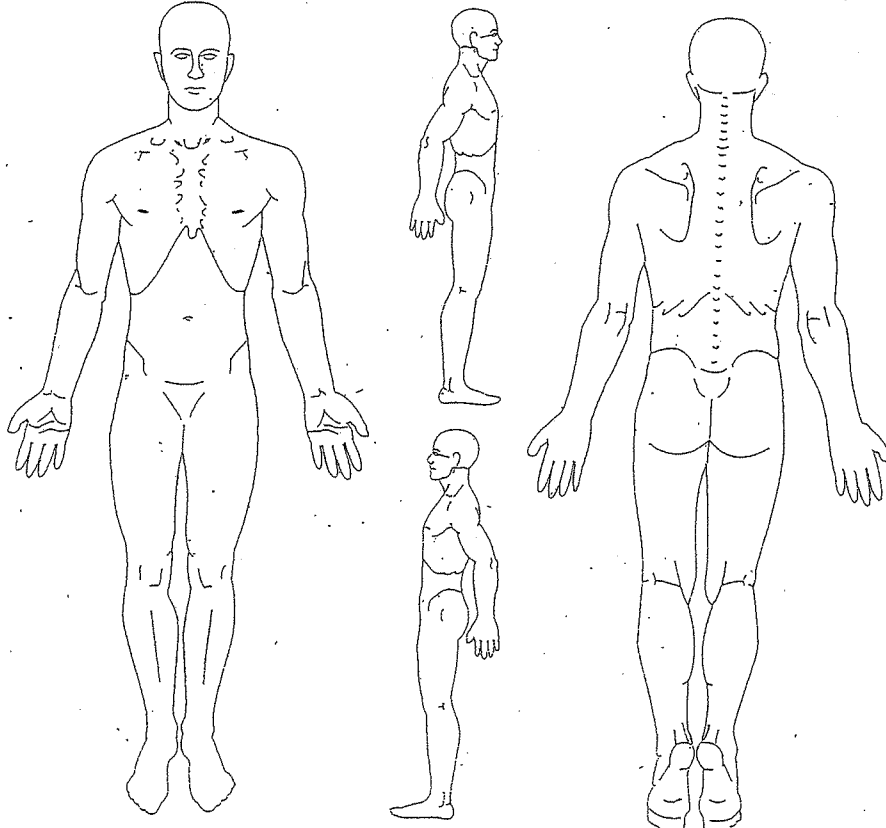
When Did Your Symptoms Begin ____ / ____ / ____ What Were You Doing When Your Pain Increased _____

On The Pain Scale, Please Rate Your Pain Or Discomfort: (0 being no pain, 10 being excruciating/unbearable pain)



Please Mark The Location Of Your Pain Or Discomfort On The Images Below. Use The Symbols Shown To Represent The Type(s) Of Pain:

D=Dull **B**=Burning **N**=Numbness **S**=Stabbing /Cutting
A=Aching **C**=Cramping **T**=Tingling (Pins & Needles)



Patient's Signature _____

Date Signed _____