OneCare Spine & Injury Centers

Today's Date: _____/____/_____ ❑ **Daytona Beach** ❑ **Palm Coast**

First Name: _____ Middle Initial: ___ Last Name: _____

Nickname you prefer? _____

Under age 18? Guardian or Parent Name: _____

Birth Date: Month: _____ Day: _____ Year: _____ Age: _____

Mobile # (_____) _____-_____

Alternate # (_____) _____-_____

***Email:** _____

Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed (required for Claim processing)

Home Address

Street: _____ Apt#: _____

City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Name you wish on file: _____ Phone: (_____) _____-_____

REASON FOR TODAY'S VISIT

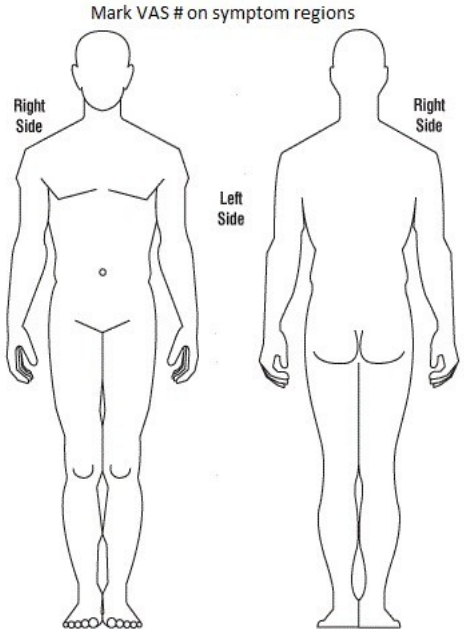
❑ Auto Accident ❑ Motorcycle Accident ❑ Slip & Fall ❑ Work Injury

* **Date of the Accident or Injury**: _____/_____/_____

❑ Wellness Visit ❑ Sports injury ❑ Independent Medical Exam ❑ Sports/School Physical

❑ DOT CDL Exam ❑ Other reason: _____

Mark all complaint areas:



Clinic Notes (include PMH):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HT: _____" WT: _____lbs Pulse: _____bpm

Resp: _____ bpm Temp: _____F B/P: _____/_____

Tobacco Use	Alcohol Use	Activity Levels (Before this injury)
❑ Never used tobacco	❑ Never drink alcohol	❑ Sedentary
❑ History of Use, but quit	❑ Light/Moderate (Socially)	❑ Light (normal daily activity)
❑ Up to 1 pack per day	❑ Heavy Drinker (2+ drinks a day)	❑ Moderate
❑ 1 to 2 packs per day		❑ Vigorous (I exercise frequently)
❑ 2 or More packs per day		

SURGERY and/or HOSPITAL STAYS (1 night or more) ◯ **I've never had surgery**

Year	Reason

MEDICATION (Prescribed and over the counter) ◯ **I am not taking any medication**

Name	Prescribed by	What Condition

Primary Care Physician: _____

City: _____

EMPLOYMENT / STUDENT

If not currently employed, are you: ❑ Student ❑ A stay at home caretaker ❑ Retired ❑ In-between jobs

Employer/School: _____Occupation: _____ ❑ Full ❑ Part Time

Employer/School: _____Occupation: _____ ❑ Full ❑ Part Time

Job Duties:

_____

Did you miss any time from work or classes?

❑ No, I have not missed any time **OR** ❑ I have missed _____ Days _____ Weeks _____ Months

Any Light Duty Available? ❑ No ❑ Yes. **If you have returned to work, are you on light duty right now?** ❑ Yes ❑ No

DIAGNOSTIC TESTS (Performed in the past 6 months)

Date	Test (XR-MRI)	Body Part or Region	Where Performed

REVIEW OF SYMPTOMS: (Please check all that apply, even if before your recent accident)

GENERAL: ◯ None of these apply

❑ Lethargy / Weakness	❑ Recurring Fever	❑ Weight gain/loss
❑ Dizziness	❑ Fever	❑ Chills

HEENT: ◯ None of these apply

❑ Headaches / Migraines	❑ Eye or vision problems	❑ Eyeglasses or contact lenses
❑ Nose Bleeds	❑ Eye Surgery	❑ Cataracts
❑ Glaucoma	❑ Sore throat	❑ Hoarseness
❑ Swollen glands	❑ Nose congestion sinus issues	❑ Ear / Hearing problems
❑ Dental Problems	❑ Gum Problems	❑ TMJ Pain
❑ Postnasal drip		

SKIN / HAIR ◯ None of these apply

❑ Skin trouble or rashes	❑ Flushing	❑ Excessive acne
❑ Eczema	❑ Psoriasis	❑ Skin cancer
❑ Skin Pigmentation issues	❑ Changes in hair or nails	❑ Blood in stool
❑ Easy bruising	❑ Other:	

CARDIOVASCULAR ◯ None of these apply

❑ Chest pains or tightness	❑ Heart Attack	❑ Shortness of breath
❑ Palpitations	❑ Swelling of feet or hands	❑ High blood pressure
❑ High cholesterol	❑ Heart murmur	❑ Blood clots
❑ Pacemaker	❑ Mitral valve prolapse	❑ Congenital heart defects
❑ Rheumatic fever	❑ Leg pain cramps with walking	❑ Varicose veins
❑ Excessive bruising	❑ Coronary artery disease	
❑ Other:		

RESPIRATORY ◯ None of these apply

❑ Persistent cough	❑ Spitting up blood	❑ Asthma or wheezing
❑ Shortness of breath	❑ Exercise intolerance	❑ Sleep apnea
❑ Emphysema	❑ Snoring issues	❑ Tuberculosis
❑ Pneumonia	❑ Breathing problems	❑ Hay fever
❑ Other:		

GASTROINTESTINAL ◯ None of these apply

❑ Loss of appetite	❑ Nausea or vomiting	❑ Diarrhea
❑ Constipation	❑ Abdominal pain	❑ Stomach ulcer
❑ Bloating/Cramping	❑ Heartburn	❑ Hemorrhoids

❑ Hepatitis	❑ Cirrhosis of Liver	❑ Difficulty Swallowing
❑ Jaundice	❑ Liver Disease	❑ Gallbladder Problems
❑ Pancreatitis	❑ Change in bowel habits	❑ Black or bloody stool
❑ Colon cancer or polyps	❑ Food sensitivities	❑ Irritable bowel syndrome
❑ Crohn's disease	❑ Gastric reflux	❑ Colitis
❑ Incontinence of bladder or bowels		

NEUROLOGICAL ◯ **None of these apply**

❑ Frequent headaches	❑ Migraines	❑ Dizziness
❑ Fainting	❑ Memory Problems	❑ Poor balance
❑ Numbness or tingling	❑ Pins and needles	❑ Epilepsy
❑ Seizures	❑ Stroke	❑ Tremors
❑ Head Injury Concussion	❑ Anxiety and/or panic attack	❑ Loss of consciousness
❑ Sleeping issues	❑ Weak muscles	❑ Loss of smell or taste
❑ Temporary loss of Vision	❑ Difficulty Concentrating	❑ _____
❑ Other:		

MUSCULOSKELETAL ◯ **None of these apply**

❑ Neck pain	❑ Shoulder pain	❑ Hip pain
❑ Mid Back pain	❑ Elbow pain	❑ Knee pain
❑ Lower Back Pain	❑ Wrist / hand pain	❑ Foot or ankle pain
❑ Arthritis	❑ Joint pain or swelling	❑ Osteoporosis
❑ Fractures (now or prior)	❑ Implants, plates, pins, screws	❑ Gout
❑ Cramping	❑ Scoliosis	❑ Spine deformities
❑ Other:		

BLOOD / LYMPH ◯ **None of these apply**

❑ Anemia	❑ Bleeding	❑ Bruising
❑ Blood clots	❑ Past Transfusions	❑ Leukemia
❑ Lymphoma	❑ HIV / AIDS	❑ Sickle cell
❑ Hepatitis	❑ Other:	

ALLERGIES ◯ **None of these apply**

❑ Seasonal	❑ Medication	❑ Food
❑ Inhaler use	❑ Latex	❑ Other:

PSYCHIATRIC ◯ **None of these apply**

❑ Alzheimer's Disease	❑ Insomnia (Can't fall asleep)	❑ Difficulty Concentrating
❑ Memory loss	❑ Confusion occurring	❑ Substance abuse treatment
❑ Depression	❑ Anxiety	❑ Agitation
❑ Irritability	❑ Suicidal thoughts	❑ Chemical dependency
❑ Use of illicit drugs	❑ Rx Medical marijuana	❑ _____

❑ Other:

ENDOCRINE ◯ **None of these apply**

❑ Diabetes	❑ Thyroid problems	❑ Sweating excessively
❑ Heat Sensitive to	❑ Cold Sensitive to	❑ Unexplained Weight Loss
❑ Unexplained Weight Gain	❑ Frequent urination	❑ Always thirsty
❑ Change in appetite	❑ Unusual Hair changes	❑ Hyperthyroidism
❑ Hormonal or glandular issues	❑ Hyperparathyroidism	❑ Testosterone deficiency
❑ Cushing's Syndrome	❑ Steroid treatments	❑ Hereditary / Genetic Disorder
❑ Other:		