CONSULTATION ADMITTANCE RECORD

(Please Print)

Name: _____Address:_____
City_____ Zip_____ Home tel#_____
cell#_____ E-mail: _____
Age_____Mo._____Day_____Yr._____ Sex M____ F____ Social Security #_____
Marital Status M__S___W___D____ Occupation_____Yrs._____
Employer_____ Address_____ Zip_____
Name of spouse_____ Insurance Name_____
ID#_____Group#_____
Referred By _____

MAJOR COMPLAINT

Describe Major Complaint in Detail_____
_____
Date When Condition First Started:_____ If Known State Cause of Pain_____
Is This Condition: Getting Worse_____ Getting Better _____ Staying Same_____
What Positions or Movements Aggravate This Condition?_____
_____
What Relieves the Pain?_____
Have You Ever Been Treated for Present Condition? Yes_____ No_____ If Yes, When? _____
Name & Address of Treating Dr. _____
What Was Done? _____
Reason for Transferring From Previous Dr._____
Have You Had a Similar Condition Before? ___If Yes, When ?_____ Were You Treated?____
Who Treated You? Dr._____Address:_____
Are You Working? _____ If No, When was Last Date Worked?_____
List Any Previous Injuries and Dates_____
List Any Operations and Dates_____
List Major Illnesses and Dates_____
List Present Medications _____
The nature of the procedure, possible alternative methods of treatment, the risks involved and the possible complaints have been fully explained to me by my physician. No guarantee or assurance has been given by anyone as to the result that may be obtained.

PATIENT'S SIGNATURE _____ DATE _____

Guardian/ Spouse's Signature Authorizing Care _____Date _____