FELLS POINT
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THE BALTIMORE BACK PAIN CLINIC, Inc.

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. *Thank You.*

Date _____ EMAIL ADDRESS: _____

Name _____ Home Phone _____

Street _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: S M W D How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Other Nearest Relative _____ Phone _____

Heard about our office through _____

List present complaints, injuries and duration:

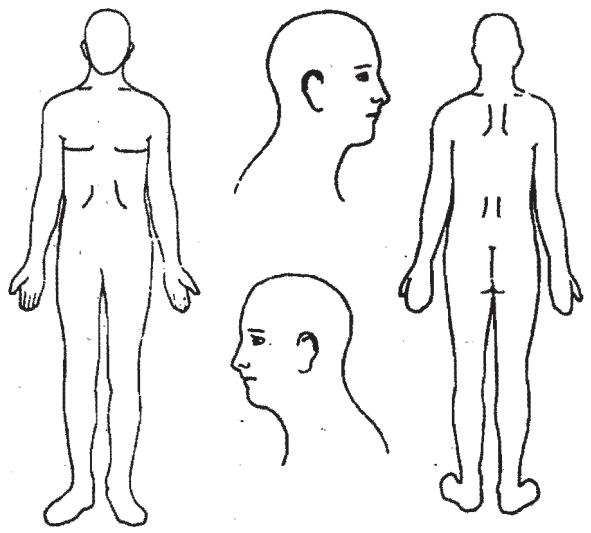
1. _____

2. _____

3. _____

Remarks and details of any accident: _____

Please mark your areas of pain on the figures below.



List other doctors consulted for present complaints and injuries:

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

Present family doctor _____

Date of last physical examination _____ By Doctor _____

PDC-1983-II-C-1-P (9)

What surgeries have you had

Type/When/Doctor/Remarks _____

_____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other — circle one)

What/When/Symptoms/Treatment/Results _____

_____

_____

List broken bones:

What/When/Remarks _____

_____

_____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks _____

_____

_____

Environment

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other _____

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other _____

Chair - Executive/Steno/Bench/Stool/Folding/Other _____ Shoes - High heels/Boots/Other _____

Leisure

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) _____

_____

Strenuous activities? Exercise - Type/Frequency/Length of time? _____

_____

Sports - Type/Frequency/Length of time? _____

If you have discontinued sports or strenuous activities, why the change? _____

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? _____

_____

Do Not Write In This Box (For Office Use Only)

1. RP
2. HL
3. T/SP
4. D/P-E
5. D/M-E
6. AA/AE
7. I N L/W
8. HR-W-E
9. OD/P-R-E
10. OD/OP-R-E
11. RDT-S
12. D/P-OP

Circle Current Conditions — Check Former Conditions

PRIMARY SYMPTOMS

MUSCULO-SKELETAL

Recurring Headaches
Eye or sinus pain
Facial spasms
Facial/jaw pain
Restricted movement-head/neck
Neck pain
Neck spasms
Poor posture
Upper back pain
Sore, aching "shawl" muscles
Pain-shoulder/arm/hand
Painful/stiff joints
Swollen arm/hand
Restricted movement-shoulder/arm/hand
Arthritis
Bursitis
Pain beneath/under shoulder blade
Pain around collar bone
Mid back pain
Chest pain
Rib cage pain
Pain beneath/below breast bone
Hiatal hernia
Restricted movement-torso
Scoliosis
Low back pain
Rheumatism
Neuritis
Neuralgia
Lumbago
Painful tailbone
Buttock pain
Hip pain
Sciatica
Swollen/painful/stiff joints-Leg/Foot
Restricted movement-Leg/Foot
Leg cramps
Leg pain-lower/upper
Foot/Toe pain
Sore/weak muscles
Walking problems

CORRELATING SYMPTOMS

NERVOUS SYSTEM

Hot/cold spots
Numbness/tingling
Dizziness
Fainting
Paralysis
Convulsions
Nervousness
Personality Change
Anxiety
Irritability
Tremors
Tension
Insomnia
Depression
Confusion
Forgetfulness
Hiccups

EYE, EAR, NOSE & THROAT

Visual disturbances
Light sensitivity
Zig Zag flashes
Eye strain
Eye inflammation
Vision problems
Chronic earache
Ear Noises
Hearing loss
Ear discharge
Nose pain
Nose bleeding
Nose discharge
Difficult breathing through nose
Sore mouth/gums
Canker sores
Dental problems
Difficulty speaking
Sinus trouble
Hayfever/allergies
Sore throat
Hoarseness
Head colds

RESPIRATORY

Difficulty breathing
Chronic cough
Coughing phlegm/blood
Asthma
Allergies
Tuberculosis
Chest colds

CARDIO-VASCULAR

Heart attack
High blood pressure
Low blood pressure
Rapid beating heart
Slow beating heart
Pain over heart
Hardening of arteries
Swelling of ankles
Poor circulation
Stroke
Varicose veins

SKIN

Skin disorder
Acne
Shingles
Itching
Bruise easily
Dryness
Boils
Hives or allergies

GENERAL

Fever
Thyroid disorder
Chills
Diabetes
Sweats
Rheumatic fever
Chronic fatigue
Cancer
Loss of weight
Weight trouble

GASTRO-INTESTINAL

Chronic nausea
Vomiting
Vomiting blood
Food allergy
Poor appetite
Excessive hunger
Difficulty chewing/swallowing
Excessive thirst
Belching gas
Gastritis/heartburn
Pain over stomach
Ulcers/stomach disorder
Distention of abdomen
Constipation
Diarrhea
Colitis
Diverticulosis
Hemorrhoids
Liver trouble
Gall bladder trouble
Jaundice
Black stool
Bloody stool

GENITO-URINARY

Urine disorder-frequent/excessive/scanty/painful discolored/blood/pus
Bladder trouble
Kidney infection/stones
Impotency
Bed wetting
Prostatitis

FEMALE

Periods-painful/excessive irregular/cramps
Hot flashes
Breasts-lumps/congested
Menopause symptoms

13. ES-E _____

14. PC-A/S _____

15. PC-PS/CS _____

16. HL _____

17. TE-DEP _____

In order to help our patients obtain all insurance benefits for which they are eligible, we will need the following information completed.

GROUP HEALTH (Please complete in addition to Auto and Workmen's Comp. info.)

Primary Co. _____ Address _____

Deductible $_____ Already Paid ☐ Yes ☐ No ☐ Not Known. Percentage Insurance Co. pays (if known) _____%

Insured _____ Ins. I.D. # _____ S.S. # _____

Other Company _____ Address _____

Deductible $_____ Already Paid ☐ Yes ☐ No ☐ Not Known. Percentage Insurance Co. pays (if known) _____%

Insured _____ Ins. I.D. # _____ S.S. # _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient's Signature X _____ S.S. # _____ Date _____

Other Responsible Party _____ S.S. # _____ Information taken by: _____

Please Complete for All Accidents

Date, time and location of accident: _____

Have you had previous complaints in the injured area? ☐ Yes ☐ No Details if Yes _____

Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Have you lost any days of work? _____ Dates: _____

Since this injury, are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

Have you ever had an accident claim before? ☐ Yes ☐ No Details _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No _____

Name of your insurance adjuster _____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe. If so, name and address _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

You were ☐ Pedestrian ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices.

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____ Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____ What treatment was given? _____

Did your car strike the other(s) involved ☐ Yes ☐ No; or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side. You were heading ☐ North ☐ East ☐ South ☐ West ☐ Parked - on _____ (street or highway)

Other vehicle was headed ☐ North ☐ South ☐ East ☐ West ☐ Parked - on _____ (street or highway)

Where police notified? ☐ Yes ☐ No. As a result of the accident were traffic citations issued to you ☐ Yes ☐ No; To the driver of the other car ☐ Yes ☐ No; To the driver of your car ☐ Yes ☐ No

Driver of other vehicle (if any) _____ Auto Ins. Co. _____ Policy No. _____

Driver of vehicle in which you were injured _____ Auto Ins. Co. _____ Policy No. _____

WORKMEN'S COMPENSATION QUESTIONNAIRE

Did you report the injury to your foreman or employer? ☐ Yes ☐ No. Name _____

Did he (they) recommend care at our clinic? ☐ Yes ☐ No. Did you continue to work after the accident? ☐ Yes ☐ No

If injured before, did you lose time from work? ☐ Yes ☐ No. If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No. If so, explain _____

In your work do you have to favor any part of your body? ☐ Yes ☐ No. If so, explain _____