INTEGRACARE CLINICS

Patient Information

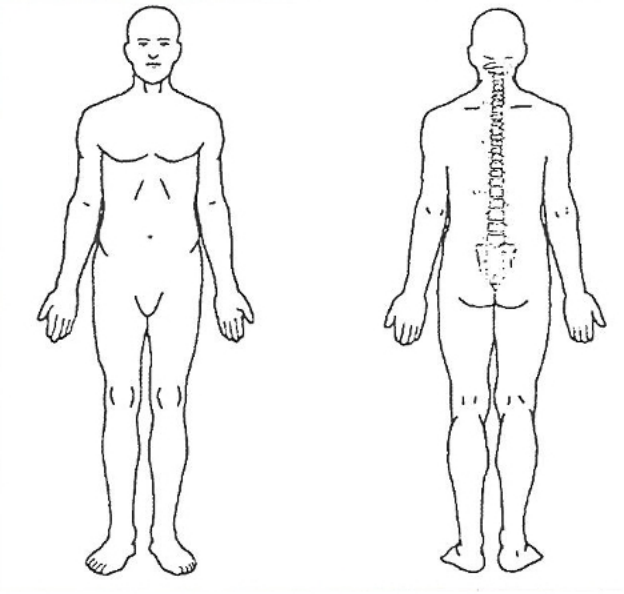
First Name: Middle Initial:

Last Name:

Date: Date of Birth: Cell Phone:

Major Complaint Information

Circle where you are experiencing pain



What is your major complaint(s)?

When did this symptom(s) begin?

If this is an injury, describe what happened:

Have you experienced these symptoms before? If so, when?

What aggravates this condition?

What decreases the symptoms/pain?

Have you seen another doctor for this condition? Yes No Doctor's Name:

Date consulted: Diagnosis:

If female, are you pregnant? Yes No Not Sure If no or not sure, date of your last menstrual period:

List all medications you are taking now, including over the counter medication:

Are you allergic to any medications? Yes No Not Sure Please list below:

Have you ever had any surgeries or hospitalizations? Yes No Please list the type of hospitalization and date it occured below:

List any known medical problems:

Who refered you to Integracare?

Check those activities below during which you experience difficulty or pain:

○Lying on back	○Getting in/out of car	○Pulling	○Sitting	○Standing for long periods
○Lying on side	○Dressing Self	○Reaching	○Bending forward	○Sneezing
○Turning over in bed	○Sexual Activity	○Kneeling	○Bending backward	○Coughing
○Lying flat on stomach	○Pushing	○Stooping	○Walking	○Other:_____

IF YOURS IS AN AUTO OR WORK ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Personal Injury

Date and time of accident: Location:

How did the accident occur? Auto collision On-the-job injury Other:

Please describe the accident or injury:

If work related, did you report the injury to your foreman or employer? Yes No

If work related, list the name and phone number of your foreman or authorized person:

If auto accident, were you: Driver Passanger Pedestrian

If auto accident, were you struck from: Behind Right Side Left Side Front Auto was parked

If auto accident, did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined Did your vehicle's airbag deploy? Yes No

Were you wearing a seat belt? Yes No Did your body strike any objects in the car? Yes No

List object(s) struck:

Lost work time: Yes No If yes, what date did you return to work?

Do you have an attorney who has advised you in this case? Yes No Attorney Name:

Attorney's Address: Attorney's Phone:

Family History

	Self Age:	Father Age:	Mother Age:	Spouse Age:	Brother(s) Age:	Sister(s) Age:	Children Age:
Arthritis							
Asthma							
Back Pain							
Bursitis							
Cancer							
Diabetes							
Disc Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Insomnia							
Kidney Trouble							
Migraines							
Nervousness							
Scoliosis							
Sinus Trouble							
Stomach Trouble							
Other							