SPINE CENTER
MYRTLE BEACH

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Gender Identity: _____ Sex at birth: _____

Address: _____

Social Security Number: _____ Preferred Language: _____

Cell Phone: _____ Home phone: _____ Work Phone: _____

Email: _____ How can we contact you? (circle all that apply): ☐ Text ☐ Phone ☐ Email

Employment Status: _____ Employer: _____ Occupation: _____

Name of Significant Other: _____ Marital status: ☐ Married ☐ Single ☐ Other

Emergency Contact Name: _____ Phone Number: _____

Race (circle one): ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ White or Caucasian ☐ Pacific Islander ☐ Decline to answer ☐ Other

Ethnicity (circle one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer ☐ Other

Name of Insurance Company: _____ Relationship to cardholder: _____

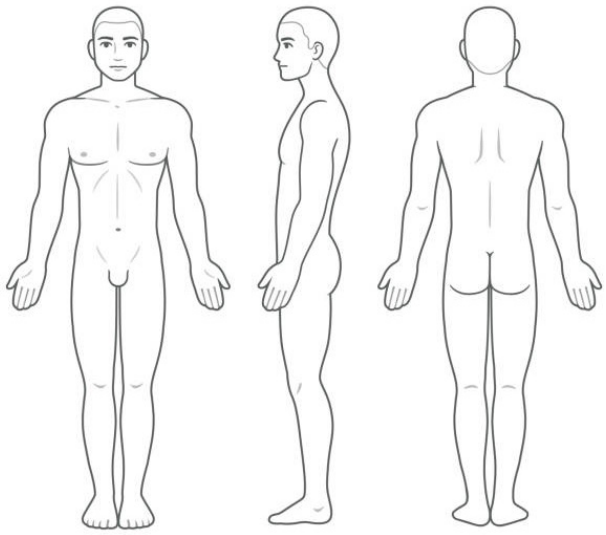
Cordholder's Name: _____ DOB: _____ SS#: _____

Cardholders Place of Employment: _____

**In order of importance, please fist the complaints/reason you are seeing the Doctor today:

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

Please mark the areas of complaints on the illustration below using the following symbols:
P = Pain N = Numbness B = Burning A = Ache T = Tenderness S = Spasm R = Radiation (where to?)



Is this due to an accident? _____ Date of Accident: _____

Do you have an attorney? _____ Name: _____

*(*** IF DUE TO ACCIDENT LET THE RECEPTIONIST KNOW IMMEDIATELY****)*

Have you ever had pain like this before? ☐ Yes ☐ No If so, when? _____

Does the pain radiate anywhere (up, down, left., or right - be specific)? _____

What is the pain like (when it is at its worst) on a scale of 1 to 10, with 10 being the worst: _____

Describe the pain (circle all that apply): ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Numb ☐ Dull Ache
☐ Other: _____

Patient Name:_____ Signature: _____ Date: _____

(if a Minor: Guardian's Name: _____ Guardian's Signature: _____)

When does the pain bother you? (circle all that apply): ☐ Night ☐ Day ☐ Constant ☐ Occasionally ☐ Daily ☐ Weekly

Has the pain cause you to miss any work or school? ☐ Yes ☐ No if so, how much? _____

When did the pain begin? _____ What were you doing at the time? _____

Have you seen any other Doctors for this pain? ☐ Yes ☐ No If so, whom? _____

How long ago did you see him/her? _____ What was the progress? (circle one) ☐ Same ☐ Better ☐ Worse

What treatments have you received already for this pain? _____

What have you tried to make the pain feel better (circle all that apply):

☐ Resting ☐ Twisting ☐ Adjustments ☐ Bending ☐ Running ☐ Walking ☐ Eating ☐ Sitting
☐ Working ☐ Exercising ☐ Sleeping ☐ Medications ☐ Lying down ☐ Ice ☐ Standing
☐ Stretching ☐ Tylenol/aleve/ibuprofen ☐ Massage ☐ Heat ☐ Other: _____

Does anything make the pain feel worse (circle all that apply):

☐ Bending ☐ Exercising ☐ Running ☐ Twisting ☐ Carrying ☐ Gardening ☐ Sitting ☐ Typing
☐ Chewing ☐ Lifting ☐ Sleeping ☐ Walking ☐ Cleaning ☐ Lying down ☐ Sneezing
☐ working ☐ Cooking ☐ Medications ☐ Standing ☐ Coughing ☐ Pulling ☐ Stretching
☐ Driving ☐ Pushing ☐ Turning ☐ Other: _____

Is there anything else you would like the doctor to know about your condition(s)? (please write it in the space below)

_____

_____

_____

_____

Who is your Primary Care Physician (PCP)? _____ When did you last see him/her? _____

PCP Address: _____ PCP Phone: _____

Personal Habits: Smoker ☐ Yes ☐ No If so, how much/how often? _____ Start date: _____

Alcohol? ☐ Yes ☐ No if so, how much/how often? _____

Exercise? ☐ Yes ☐ No if so, how much/what type? _____

Are you currently Pregnant? _____ Date of last menstrual cycle? _____

***if you are pregnant, please notify the doctors and staff during your consultation****

Please list all of your allergies (Medication I Food I Environmental I etc):

_____

_____

Please list all the over the counter medicine you are taking and the dosage (vitamins, Tylenol, A/eve, allergy medicine, etc):

_____

_____

Please list all of the prescription medication you are taking and the dosage and frequency:

_____

_____

Please list any surgeries or hospitalizations and when they occurred:

_____

_____

How did you hear of our office? _____

*I attest that the information that I filled out is accurate to the best of my knowledge and I agree to have this office and physician examine me for further evaluation. This <u>may</u> include: consultation, examination, x-rays (if necessary). If the patient is a minor, I attest that I am legally allowed to provide this consent.*

Patient Name: _____ Signature: _____ Date: _____

(if a Minor: Guardian's Name: _____ Guardian's Signature: _____