

Patient History

Date of Birth _____ Social Security Number _____ - _____ - _____
Last Name _____ First Name _____
Home Address _____ Apt # _____ City _____ ST _____ Zip _____
Phone (H) _____ (W) _____ (Cell) _____
Employer (Company Name) _____ Your Occupation _____
Employer Address _____ City _____ St _____ Zip _____
Emergency Contact _____ Phone _____
Spouse's Name _____ Spouse's Occupation _____
Have you ever been to another doctor for this problem? Y N (please circle)
Who referred you to this office? _____
EMAIL: _____

WHAT BRINGS YOU TO OUR OFFICE?

PRIMARY COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Please mark an X on the line describing the intensity of your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

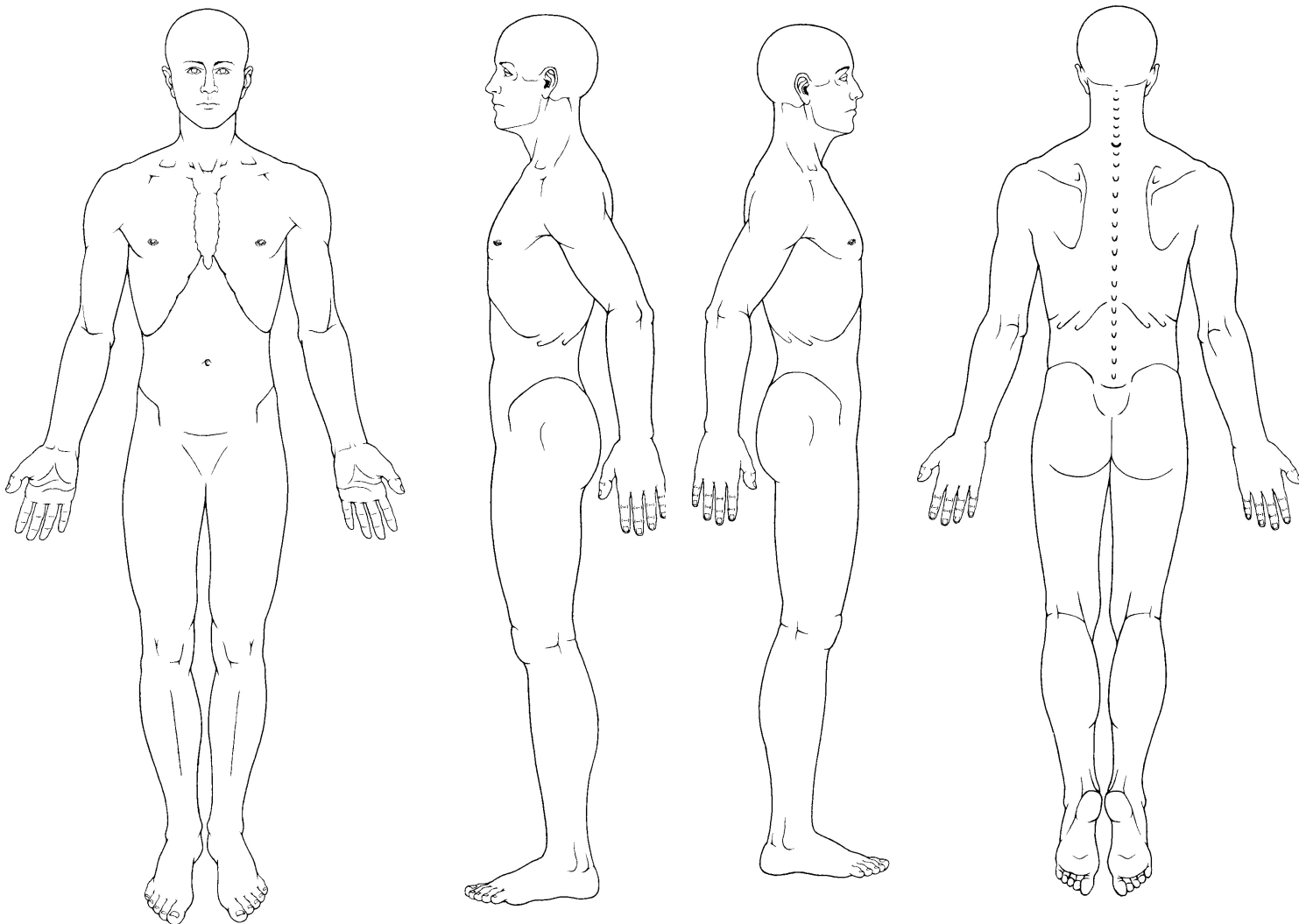
SECONDARY COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Please mark an X on the line describing the intensity of your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

PATIENT SIGNATURE _____ DATE _____

PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately
describe your condition.**

- P - Where you experience Pain**
- N - Where you experience Numbness**
- T - Where you experience Tingling**
- B - Where you experience Burning**
- C - Where you experience Cramping**

PATIENT SIGNATURE _____ DATE _____

Patient History

INSURANCE INFORMATION

Name of Insurance Company: _____

Address: _____

(City) (State) (Zip)

Phone #: _____ Policy Holder's SS#: _____

Policy/ID #: _____ Group #: _____

Policy Holder's Name: _____
(Last) (First) (Middle Initial)

Relation to Policy Holder: (Circle one) Self Spouse Child

Birth date of Policy Holder: _____ (mm/dd/yyyy)

Policy Holder's Employer: _____

BENEFICIARY/PATIENT AUTHORIZATION

I hereby authorize Philip Golinsky, D.C. to release any medical information necessary to adjudicate and process my insurance claims, and request payments of benefits be made directly to Philip Golinsky, D.C. The office of Philip Golinsky, D.C. will submit fees for services rendered to my insurance company for payment. I understand that I am responsible for payment in full, for any fees not paid by my insurance company.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____

PATIENT SIGNATURE _____ DATE _____