

Dr. Robert Pashman

New Patient History Form

Date:

Referred By: Specialty:

Address: Phone Number:

Patient Name: Home Phone: Cell Phone:

Home Address: City, State, Zip:

email Work Phone: Fax Number:

Marital Status: Married Single Widowed Divorced Sex: Date of Birth:

SSN Religious Preference: Ethnic Group:

Patient Employer Name: Occupation:

Employer's Address: Employer's Ph#:

Emergency Contact: Contact Ph# & relation

Complaint:

Worker's Comp Attorney: Phone #:

Auto Injury Address: DOI:

Personal Injury

Primary Insurance: HMO PPO POS Insurance Ph#

Insurance Address: Group#:

ID# Effective Date: Coverage Code: Subscriber Name:

If patient is not the subscriber: DOB SS# ***of the subscriber***

Employer Name: Occupation: Phone:

Employer Address:

Film Status:

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Patient Name:

Secondary Insurance: HMO PPO POS

Insurance Address: Insurance Ph#

Group# ID# Effective Date: Coverage Code:

Workers Compensation (if applies)

Name of Insurance Carrier:

Address of Insurance Carrier:

Name of Adjuster: Adjuster Ph#: Adjuster Fax#:

Claim #: Date of Injury:

Name of Employer at time of injury:

Address of Employer at time of injury:

Phone# of Employer at time of injury:

Patient History

Name: Date: Age: Occupation:

Referred By:

When did symptoms first appear? Are they symptoms:

Body parts
Affected:

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Type of Pain:

Pain Radiation:

Degree of pain you are currently experiencing:

Please describe any other symptoms:

What position and/or medication relieves or pain?

Do you have any pain, numbness, tingling, or weakness in you arms or legs?

Are you presently working:

If you are on disability when did it begin?

Have you had any treatment (including xrays, tests, therapy, ect) or seen any health provider for this injury? Please describe?

Have you tried any home treatments or medications? Please describe:

Please list previous diagnosis and treatments given or recommended?

Please list any test you have had in the past related to your problem (MRI, X-Ray, Etc.)

Test/Study: Test Date: Result:

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Patient Name:

Test/Study: Test Date: Result:

Notes:

Have you recently had any of the following (check all that apply)

- | | | | | |
|------------------------------------------------|---------------------------------------------|----------------------------------------------|-------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fainting | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Depression | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Difficulty Voiding | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sleep Difficulty | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Early Awakenings | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Loss of Concentration | | | | |

Are you:

describe:
above
symptoms

Are you pregnant?

Past medical history: Please check any of the following which you have had:

- | | | | |
|-----------------------------------------------------------------|---------------------------------------------------|------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Respiratory problems, asthma, hayfever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Gastrointestinal problems, ulcers | <input type="checkbox"/> Arthritis, Gout | <input type="checkbox"/> Circulatory/CVA | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Depression, Psychological | <input type="checkbox"/> Drug Abuse/Alcohol Abuse | <input type="checkbox"/> Liver Problems | |
| <input type="checkbox"/> Problems with ears, eyes, nose, throat | <input type="checkbox"/> Diabetes, Hypoglycemia | <input type="checkbox"/> Hypertension | |

Please explain any of the above

Have you had any prior surgeries? Please describe

Have you had any previous spine surgeries? If so, type and date:

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New Patient History Form

Patient Name:

Are you currently seeking treatment for any other medical conditions?

Please list all medications you are taking and the daily dosage:

Are you taking any herbal or vitamin supplements? If so, please list:

Are you allergic to any medications, food, other? If so, please list:

Family Medical History:

Is there a history of Spinal problems in your family?

If yes, please explain:

Is there a family history of other medical problems? If so, please describe:

Social History:

Age:

Height:

Weight:

Marital Status:

Children:

Do you smoke?

If yes, how much?

Is there any history of drug or alcohol abuse?

Do you drink alcohol?

If yes, how much?

Describe usual physical activity: type and frequency:

Primary Care Physician:

Name:

Address:

Phone:

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New Patient History Form

Automobile Injury History

Date of accident Time: Where did the accident occur?

Describe the accident
in your own words:

What was your position in the car?

If passenger, were in sitting in the:

Did you strike the other vehicle?

Was your car struck by the other vehicle?

Was the impact from the

At the time of the impact: were you:

Were both hands on the steering wheel?

Was your foot on the brake?

Were you wearing a seatbelt?

Were you braced for impact?

Where were you in the car after the accident?

Did you strike anything in the vehicle at the time of impact?

If yes, specify:

Please state part of body:

Were you unconscious? In a daze?

Did you go to the hospital

How did you get to the hospital?

Name of hospital:

Did the ambulance place you in: Neck Collar Splints Brace

Attending Dr.

Were xrays taken

What was the diagnosis?

Were you admitted to the hospital?

How long did you stay?

What treatment did you receive?

Describe your symptoms from the day
following your accident to today's date.

What recommendations were made? See own doctor See specialist Physical Therapy

Before your injury, were you capable of working on an equal basis with others your age?

Are your work activities restricted due to accident?

Are your home activities restricted as a result of this accident?

If yes, percentage of restriction

Do you have a copy of the police report?

If yes, please bring a copy of the report with you to
your doctor's appointment.

Signature Field

Date:

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