

WELCOME TO OUR OFFICE !

Please Print

Patient's Name _____
First Middle Initial Last

Address _____
Street City State Zip

Home Phone # _____ Sex (circle) Male Female
Area Code

Cell Phone # _____ E-mail Address _____

Marital Status (circle) Single Married Divorced Widowed

Date of birth _____ Social Security # _____

Employment Status (circle) Student Homemaker Retired Employed

If Employed:
Employer _____ Work Phone # _____
Area Code

Work Address _____
Street City State Zip

Referred to our office by _____

In case of emergency, contact _____
Name Phone No.

Person (if someone other than patient)
responsible for payment of this account _____
Name Relationship to Patient

All fees are the responsibility of the patient or the responsible party listed above. As a courtesy to me, this office will file the insurance claim for me. However, should the balance not be paid by the insurance company, I understand it will be my responsibility to pay the account balance. I also understand that if my account is forwarded to collections, I will be responsible for any and all additional charges added to my past-due account plus any charges for litigation, attorney fees, court costs and filing fees. I hereby authorize payment to Dr. Robert Beck of benefits due me for his services as described. I also authorize the release of any and all medical information relating to this claim.

Signature of Patient or Responsible Party _____

Date _____

Primary Care Physician _____

Your general health (circle) GOOD FAIR POOR

List any medications you are now taking _____

What are you here for today? _____

How long have you had this problem? _____

Did you see a doctor for this condition? _____ Doctor's name _____

Did you have X-rays, MRI, or other tests? _____

If so, where? _____ When? _____

Is your present condition related to employment? _____

If so, please give the date of accident _____

Is present condition related to an automobile accident? _____

Date of accident _____

Related to any other accident? Date _____

Describe _____

Insurance Carrier _____ Phone # _____

Policy/Member # _____ Group # _____

If insured is someone other than patient: Name _____

SS# _____ Date of birth _____

Secondary Ins. Carrier _____ Phone # _____

Policy/Member # _____ Group # _____

If insured is someone other than patient: Name _____

SS# _____ Date of birth _____

PAIN DIAGRAM

NAME: _____

AGE: _____

DATE: _____

How long have you had this problem? _____

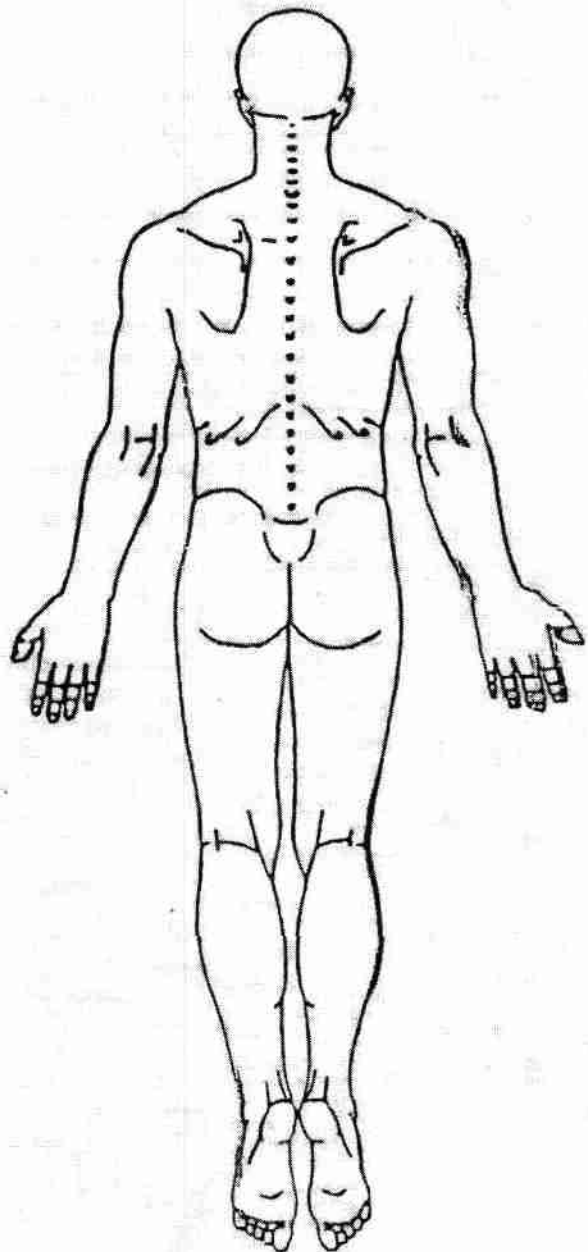
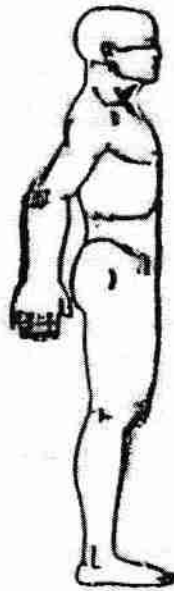
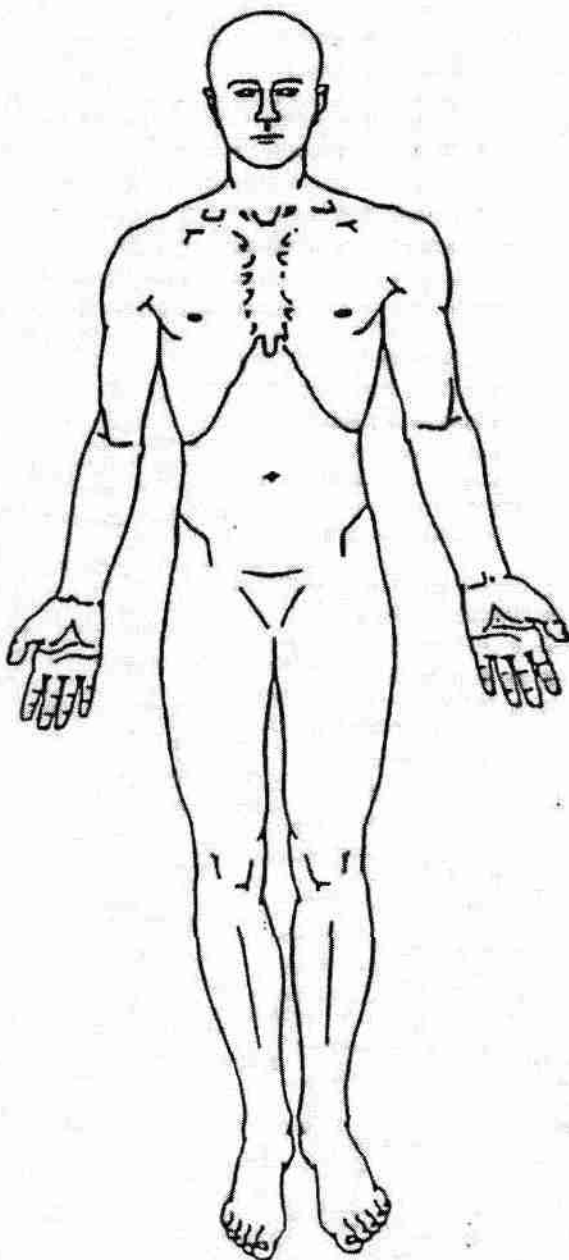
Is this your first episode of this pain/discomfort? _____

On these diagrams, please mark where you are experiencing pain/discomfort right now.
Use the letters below to indicate the type of discomfort.

A= Ache
B= Burning

N= Numbness
P= Pins & Needles

S= Stabbing
O= Other (explain)

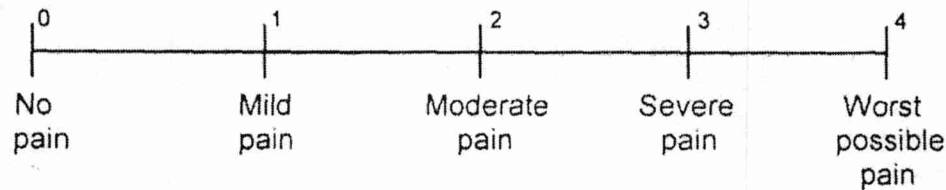


Functional Rating Index

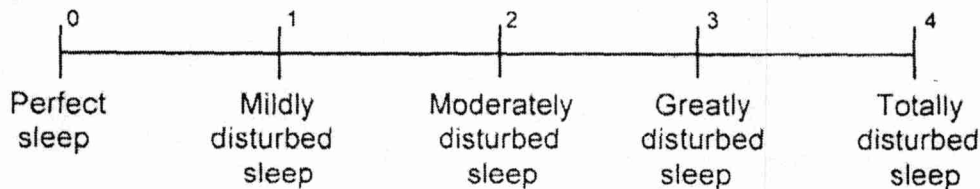
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

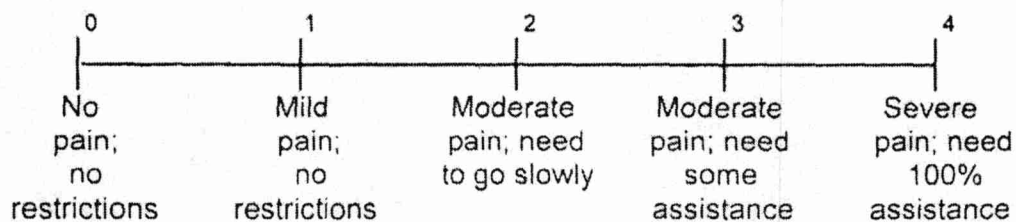
1. Pain Intensity



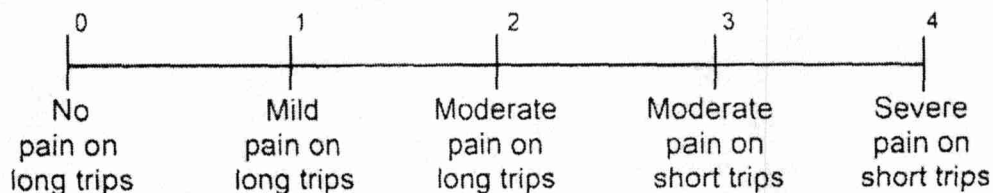
2. Sleeping



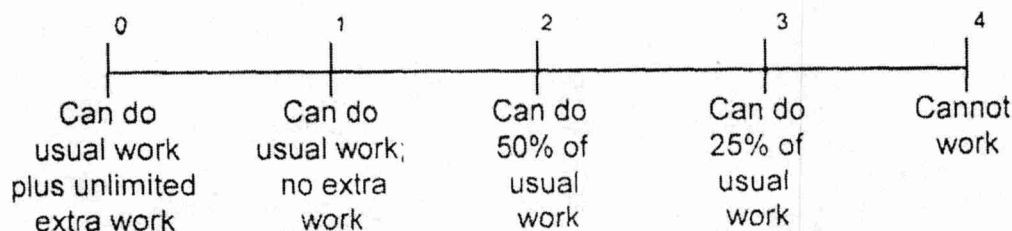
3. Personal Care (washing, dressing, etc.)



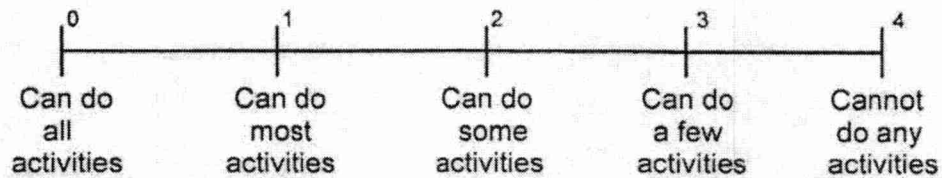
4. Travel (driving, etc.)



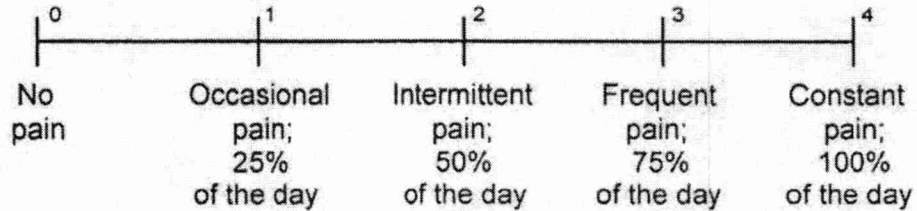
5. Work



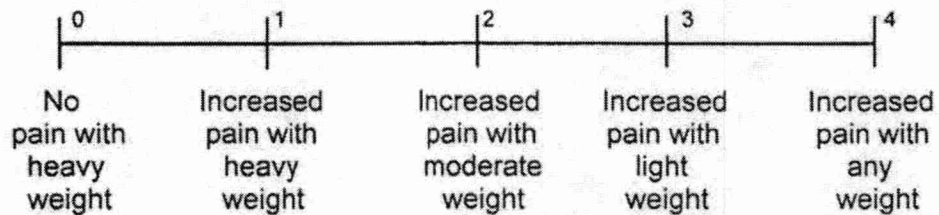
6. Recreation



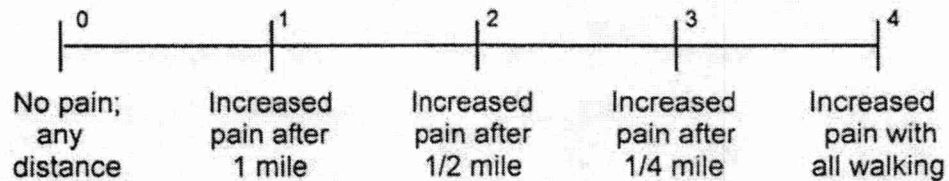
7. Frequency of pain



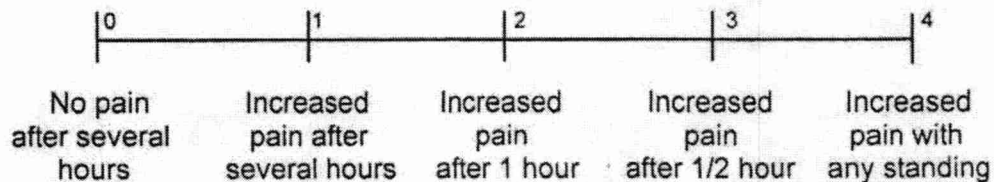
8. Lifting



9. Walking



10. Standing



Patient's Signature

Date

Score =