Dearinger & Klindt CCC, PLLC

107 N. 5th Street

Bardstown, KY 40004

Phone: 502-348-3202 Fax: 502-348-0321

**CONFIDENTIAL PATIENT INFORMATION**

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# **How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Gender: M - F Shoe size: \_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married - Single - Widowed - Student

Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse's DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse's employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse's SS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any Allergies:**

 Animals  Aspirin  Bees  Chocolate  Dairy  Dust  Eggs Latex  Molds  Penicillin  Ragweed/Pollen

 Rubber  Seasonal Allergies  Shellfish  Soaps  Wheat  X-Ray Dye  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Surgeries:

 Back  Brain  Elbow  Foot  Hip  Knee  Neck  Neurological  Shoulder  Wrist  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List ALL Past Medical History conditions:**

 Ankle Pain  Arm Pain  Arthritis  Asthma  Back Pain  Broken Bones  Cancer  Chest Pain  Depression

 Diabetes  Dizziness  Elbow Pain  Epilepsy  Eye/Vision Problems  Fainting  Fatigue  Foot Pain

 Genetic Spinal Condition  Hand Pain  Headaches  Hearing Problems  Hepatitis  High Blood Pressure

 Hip Pain  HIV  Jaw Pain  Joint Stiffness  Knee Pain  Leg Pain  Menstrual Problems  Mid-Back Pain

 Minor Heart Problem  Multiple Sclerosis  Neck Pain  Neurological Problems  Pacemaker  Parkinson’s

 Polio  Prostate Problems  Shoulder Pain  Significant Weight Change  Spinal Cord Injury  Sprain/Strain

 Stroke/Heart Attack  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Type of Medications you are taking:**

 Anxiety  Muscle Relaxers  Pain Killers  Insulin  Birth control  Cardiovascular  Allergy  Seizure

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List your Family History:**

 Arthritis  Asthma  Back Pain  Cancer  Depression  Diabetes  Epilepsy  Genetic Spinal Condition

 High Blood Pressure  Heart Problems  Multiple Sclerosis  Neurological Problems  Parkinson’s  Polio

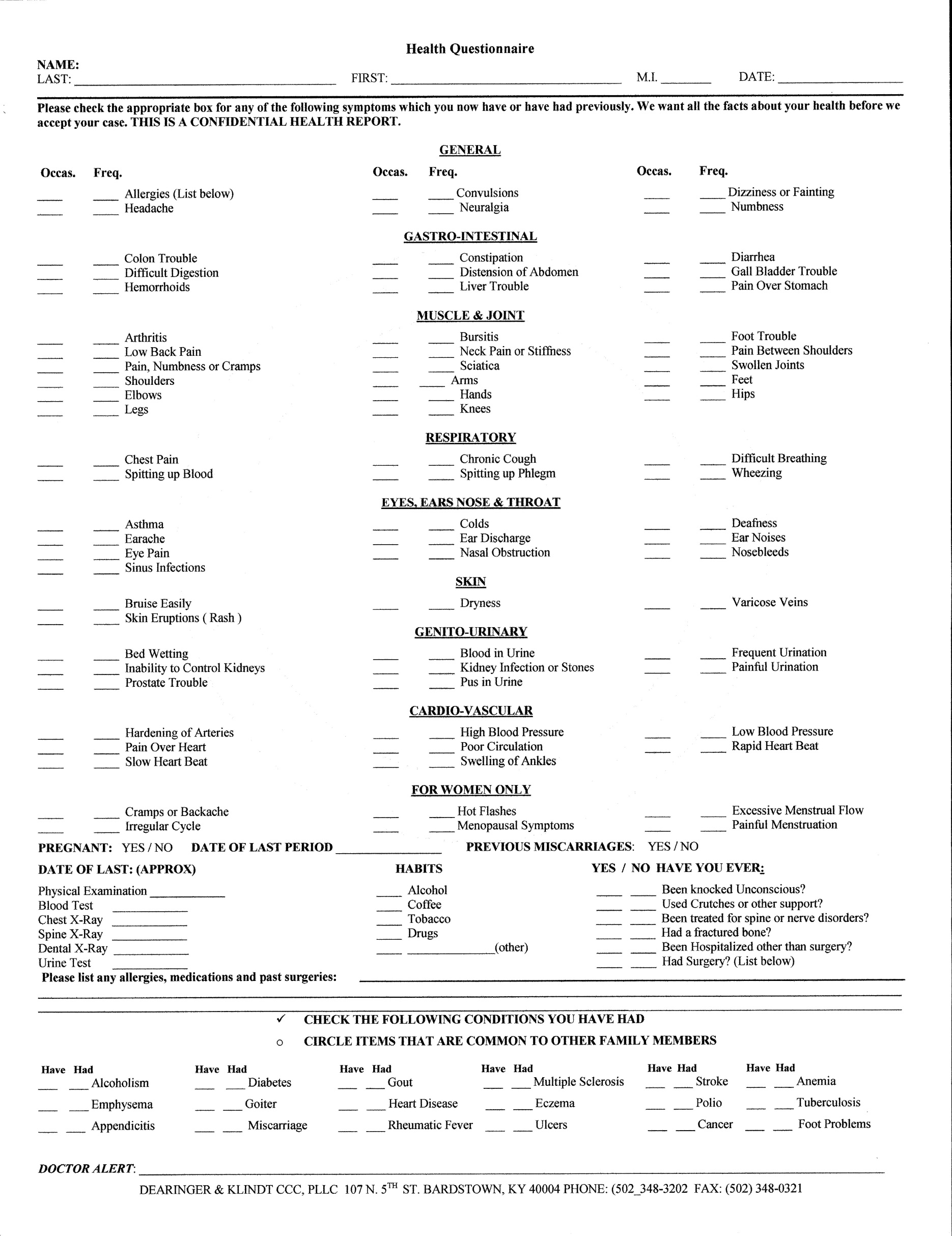
 Prostate Problems  Stroke/Heart Attack  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list family member with this medical history (ex. mother, father etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any auto or other accidents?  No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke?  No Yes

Do you drink alcohol?  No Yes - how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeine?  No Yes - how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise?  No Yes (what forms and how often): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main reason for consulting the office:**

 Become pain free

 Explanation of my condition

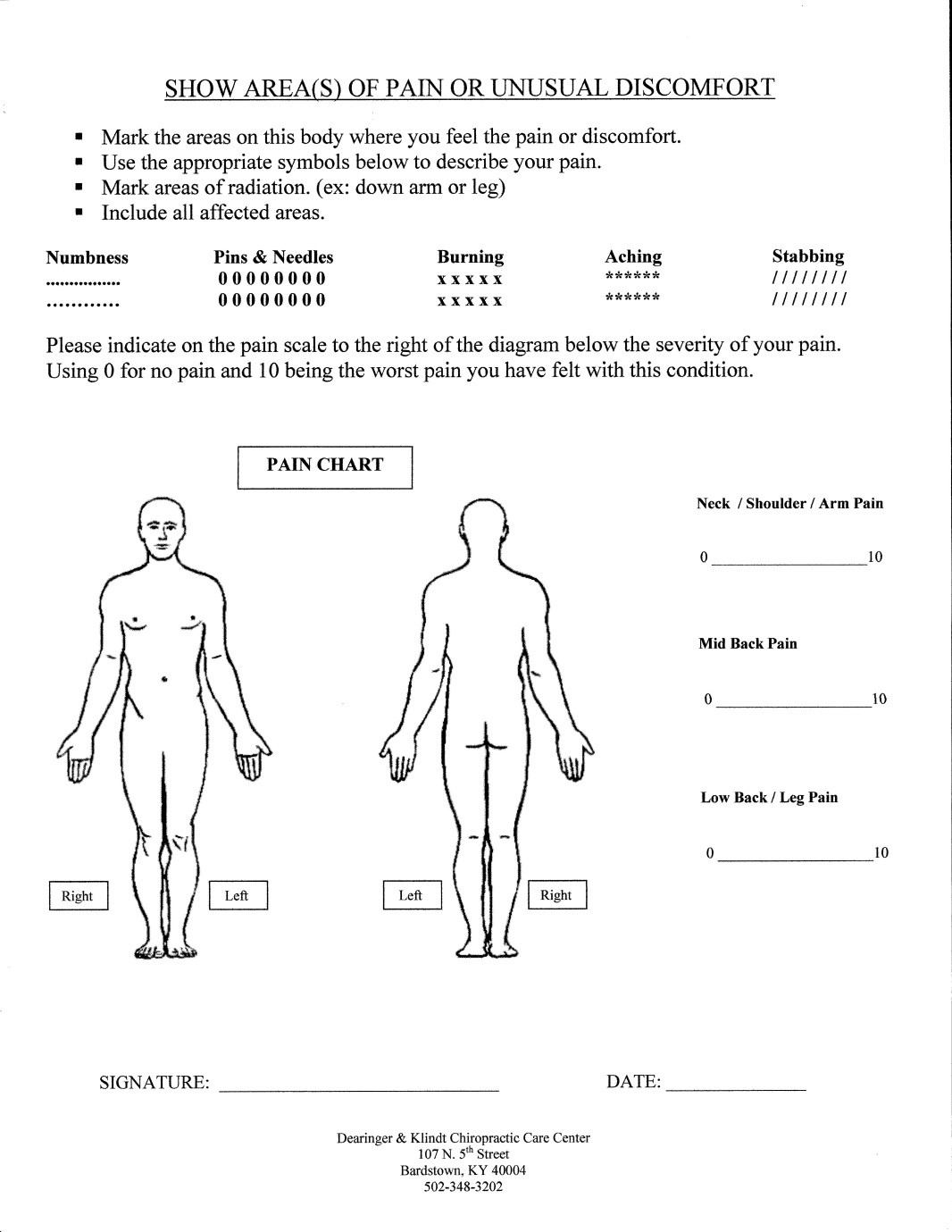
 Learn how to care for my condition

 Reduce symptoms

 Resume normal activity level

**What is your major complaint?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date problem began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which side? Right Left Both

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW**

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

 Constantly (76-100% of the day)  Frequently (51-75% of the day)

 Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms:  Sharp  Dull  Numb  Burning  Shooting  Tingling  Radiating Pain

 Tightness  Stabbing  Throbbing  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

 1  2  3  4  5  6  7  8  9  10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities)  1  2  3  4  5  6  7  8  9  10

What activities aggravate your condition (working, exercise, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your SECOND complaint?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date problem began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which Side? Right Left Both

****How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

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What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment**. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on indebtedness together with such collection costs and reasonable attorney fees as may be require to effect collection.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_