HealthQuest

CONFIDENTIAL PATIENT INFORMATION

Patient's name: ______________________________ Today's Date: ______________

First Middle Initial Last

Symptom Chart

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols shown below.

Numbness	Pins + Needles	Pain	Weakness
NNNNNNN	OOOOOOO	PPPPPPP	WWWW
NNNNNNN	OOOOOOO	PPPPPPP	WWWW

right left left right

Front Back

Visual Analog Scale

Please place an (X) along the line below which represents your current level of pain involving your major area of complaint.

NO PAIN WORST PAIN

Current Medication (with Dosage) **Condition**

___________________ ___________

___________________ ___________

___________________ ___________

___________________ ___________

___________________ ___________

Vitamins

____

____

Surgery **Date**

____

____

____

Chief Complaint Information

Primary Reason for Visit: ______________________

When did your symptoms begin? ______________________

Was it ___ sudden or ____ gradual?

Is your condition related to an injury? (car accident, work related, sports, a fall, or other) ______________________

Is your condition hindering your activities at work/ home? If so whi ch?______________________

Please describe your symptoms as best you can.

____

____

____

____

____

What activities were you engaged in when your symptoms started?

____

If applicable, at what time of day are your symptoms worse?
___Morning ___ Later in the Day ___ at Night ___ Always Same

If applicable, what is the character of your pain?
___Burning ___ Electric Shock ___ Sharp ___ Shooting
___ Stabbing ___ Dull Ache ___ Other ______________

Have you had these same symptoms previously?: If so when?

____

Anything that makes the symptoms better?: (position, activity)

____

Anything that makes the symptoms worse? (position, activity)

____

Aggravating Factors:
___ Lifting ___ Standing ___ Climbing Stairs ___ Movement
___ Walking ___ Driving ___ Sitting ___ Coughing
___ Sneezing ___ Arm Overhead ___Straining at Bowels
___ Other ______________________

How often are you experiencing symptoms?
___ Every Day ___ Frequently ___ Occasionally ___ Rarely

What is the duration of your symptoms?
__Constant __ Intermittent __ With Activity __ Sleep Disturbed

What is the intensity of your symptoms? 0— 10 (10 is worst)_____

Does the pain stop you from walking certain distances? __ Y __ N
Distance?______________________

How long can you sit before symptoms begin? ______________
How long can you stand before symptoms begin?______________
Have changes occurred in your bowel, bladder, or sexual function?

____

Have you had any treatment of any kind for this condition?: _________

GENERAL HEALTH HISTORY

Check symptoms you have or have had in the past.

GENERAL SYMPTOMS
- [ ] Fever
- [ ] Chills
- [ ] Night Sweats
- [ ] Just Don't Feel Well
- [ ] Fatigue

SLEEP
- [ ] Trouble Sleeping
- [ ] Excessive Tiredness
- [ ] Snoring
- [ ] Restless Sleep

MOOD
- [ ] Depression
- [ ] Anxiety
- [ ] Stress
- [ ] Feeling Down

WEIGHT
- [ ] Weight Loss
- [ ] Weight Gain

NOSE & THROAT
- [ ] Runny Nose
- [ ] Stuffy Nose
- [ ] Cough
- [ ] Sore Throat

GENERAL NEUROLOGIC
- [ ] Headache
- [ ] Dizziness/Fainting
- [ ] Seizure
- [ ] Loss of Consciousness
- [ ] Numbness / Tingling
- [ ] Muscle Twitching
- [ ] Weakness
- [ ] Memory Problems
- [ ] Imbalance
- [ ] Tremor
- [ ] Shooting Pains
- [ ] Speech Problems
- [ ] Incoordination
- [ ] Difficulty w/Word Retrieval
- [ ] Other

SEXUAL
- [ ] Decrease Libido
- [ ] Difficulty Achieving Erection
- [ ] Difficulty Having an Orgasm

CARDIOVASCULAR
- [ ] Chest Discomfort/Pain
- [ ] Irregular Heart Beat
- [ ] Palpitations
- [ ] Exertional Leg Pain
- [ ] Swelling of Ankles

RESPIRATORY
- [ ] Shortness of Breath
- [ ] Pain w/ Breathing
- [ ] Wheezing

GENITO-URINARY
- [ ] Urinary Incontinence
- [ ] Difficulty Making it to Bathroom
- [ ] Difficulty Voiding Bladder
- [ ] Blood in Urine
- [ ] Change in Urine Color

SKIN
- [ ] Rash
- [ ] Acne
- [ ] Other Skin Lesions

GASTROINTESTINAL
- [ ] Constipation
- [ ] Loose Stools
- [ ] Blood in the Stool
- [ ] Incontinence of Bowel
- [ ] Trouble Swallowing
- [ ] Nausea
- [ ] Vomiting
- [ ] Belly Pain
- [ ] Heart Burn

EYES
- [ ] Double Vision
- [ ] Change in Vision in One Eye
- [ ] Blind Spot
- [ ] Seeing Lines
- [ ] Hallucinations
- [ ] Flashing Lights or Stars

EARS
- [ ] Changing in Hearing
- [ ] Ringing in the Ears
- [ ] Ear Pain
- [ ] Ear Drainage

SPINE & EXTREMITY COMPLAINTS

Check symptoms you have or have had in the past.

NECK (CERVICAL SPINE)
- [ ] Neck Pain
- [ ] Muscle Spasms in Neck
- [ ] Neck Feels Out of Place
- [ ] Pinched Nerve in Neck
- [ ] Neck Stiffness

MID-BACK (THORACIC SPINE)
- [ ] Resting Mid-Back Pain
- [ ] Mid-Back Pain
- [ ] Pain From Front to Back
- [ ] Muscle Spasms in Mid-Back
- [ ] Mid-Back Stiffness

LOW BACK (LUMBAR SPINE)
- [ ] Low Back Pain
- [ ] Muscle Spasm in Low Back
- [ ] Low Back Stiffness
- [ ] Low Back & Abdominal Pain
- [ ] Low Back Feels Out of Place

BODY REGION	PAIN		WEAKNESS		STIFFNESS		NUMBNESS		TINGLING		SWELLING		PAIN W/ EXERTION	
	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
Hand	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hip	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Foot	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Face	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family History									**Please place an X for all that apply**
Family Member	**Age**	**Living**	**Deceased**	**Cancer**	**Heart Disease**	**Diabetes**	**Stroke**	**Neurologic Disease**	**Back or Neck Problems (Surgery)**
Father	________								
Mother	________								
Sibling (M/F)	________								
Sibling (M/F)	________								
Sibling (M/F)	________								

Allergies: **Substance** **Reaction**

_________________________ ____ ____
_________________________ ____ ____
_________________________ ____ ____
_________________________ ____ ____

Health / Habits:

Do you smoke? Yes No ___ # Packs per day <10yrs > 10 yrs (circle)

Did you quit smoking? _______ years ago Smoked for ______ years ______ #Packs / day

Alcohol Use? None < 5 >10 PER / Day PER Week PER Month PER Year

Exercise? None Mild Occasional (vigorous)<4X/per week Frequent (vigorous) 4 X per week

Type of Exercise: Walking Running Resistance Training Sports ____

Bike Riding Hiking Activities ____

Please Rate Your Health: Deceased 0——————————————10 Perfect Health for Your Age: ____________

Please indicate what you perceive to be your healthiest organ system and why: ie: heart, lungs, digestion, bones, brain
____

Please indicate what you perceive to be your weakest organ system? ____

What do you enjoy in your life, ie: people / activities/ relationships / relaxation?
____
____

If anything, what aspect of your life / health would you like to see change for the better?
____
____

We thank you for your time in filling out this paperwork and the trust you have in our office. We are dedicated to you as a patient. As you will come to know, we will hold each other accountable in helping you reach your health goals. Please do not hesitate to ask questions or share concerns you have about your health and well being.

We look forward to you being a part of our HealthQuest family.

I certify that the above information is correct to the best of my knowledge. I have provided a thorough and accurate personal and family history in order to assist my physician and his/ her staff to provide the appropriate care. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize **Dr. David C. Kolbaba & Associates** to utilize all contacts listed on this form. I hereby grant my permission to utilize my e-mail address to send information to me, including but not limited to newsletters and notice of other upcoming events that **DR. DAVID C. KOLBABA & ASSOCIATES** deems necessary to convey in electronic form.

RELEASE OF MEDICAL RECORDS: I authorize the release of any and all of my healthcare related medical information obtained during the course of my care whether received directly or indirectly by Dr. David C. Kolbaba & Associates to other health care providers of my designation.

PATIENT SIGNATURE (or guardian) _______________________________________ **DATE**_____________

Patient Registration

Patient Name: ______________________________ Date: ____________________
First Middle Initial Last

Your Address: ____
Street City State Zip code

Date of Birth:____________________

Home Telephone# ( ) _______ - ____________ Work Telephone# ( ) _______ - ____________ext.( )
(Cell) Phone ( ) _______ -____________ E-mail Address: ____________________
Occupation: ____________________ Employer: ____________ Phone #: __________
Spouse/Significant Other: ____________________ Marital Status: ____________________
Emergency Contact:
Name: ____________________ Telephone# ( ) _______ - ____________Ext.( )

How did you hear about us? (Please be Specific)
Physician: ____________ Phone ____________
Friend: ____________________
Family : ____________________
Other: ____________________

Who is your primary care physician?
Physician: ____________________
Specialty: ____________________
Address: ____________________
Phone ____________ Fax: ____________

This Section is for Worker's Compensation or Personal Injury Only

Is this claim: o Work o Auto o Other Claim #: ____________ Date of Injury: ___/___/___

Insurance Name & Address: ______________________________
Person in Charge of Case: ____________________ Phone #: ____________

Please Provide Insurance Card & Identification

Primary card holder: (If different from above)
Name: ____________________ DOB: ___/___/___

PATIENT AGREEMENT, IRREVOCABLE ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL DOCUMENTS

In consideration of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **DR. DAVID C. KOLBABA & ASSOCIATES** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges and outstanding balances regardless of any applicable insurance or benefit payments including attorney's fee and court costs if account becomes delinquent. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to **DR. DAVID C. KOLBABA & ASSOCIATES** to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chosen in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named clinic and claim and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Furthermore, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chosen in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense.

If the patient is a minor, the parent or legal guardian gives permission for examination and treatment at this facility. This assignment is irrevocable and I request that any attorney working on my behalf cooperate, assist and not interfere with my medical provider in recovering any MedPay or Medical Pay coverage that my provider is entitled to. A photocopy of this assignment is to be considered as valid as the original.

All co-pays, self-pay, and insurance deductibles are due at the time of service. After 90 days of non-payment, 9% interest will accrue on my account balance. I have read and fully understand this agreement.

Patient/Guardian Signature: ____________________ *Date:* ____________

Witness: ____________________