

Canby Spine & Sport

130 SW 2nd Avenue, Suite #101 Canby OR 97013 – (503) 263 – 3033

Personal Injury Intake

Name: _____ Preferred Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Email: _____

Male/Female Age: _____ Date of Birth: _____ Martial Status: M, S, D, W

Cell Phone: _____ Would you like to receive text reminders for appts? Y N

Serv Prov (Circle One): At&t – Boost – Cricket - Merto PCS – Nextel – Sprint - T-Mobile - US Cellular – Verizon - Virgin

Employer: _____

Work Phone: _____ Occupation: _____

Insurance Information

Auto Insurance Co: _____ Policy #: _____

Agents Name: _____ Agents Ph: _____

Name on Policy (if other than self): _____ Accident Claim #: _____

Claim Adjuster's Name: _____ Adjustors Ph: _____

Attorney's Name: _____ Attorney's Ph: _____

How did you hear about our office? _____

Medical History

Please check all that apply to you:

None Apply

No Yes Condition

- Recent Trauma
- Recent Fever/Infection
- Sleep Apnea/CPAP
- Diabetes
- High Blood Pressure
- Heart Disease
- Stroke (Date) _____
- Aortic Aneurysm
- Epilepsy/Seizures
- Arthritis
- Osteoporosis
- Cancer/Tumor
- HIV/AIDS
- Surgeries (List) _____
- Medication (List) _____
- X-Rays, MRI, CT Scan (List) _____

No Yes Condition

- Birth Control Pills
- Pregnancy, # of Births _____
- Abnormal Weight Gain Loss
- Urinary Tract Infection
- Frequent Urination
- Prostate Problems
- Visual Disturbances
- Dizziness/Fainting
- Corticosteroid Use
- History of Alcohol Use
- History of Tobacco Use
- History of Neck pain
- History of Mid/Low Back Pain

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete to the best of my knowledge. I here by authorize this office and its Doctors to administer care to me as they deem necessary. I assign directly to Canby Spine & Sport all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature _____ Date _____

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Patient Symptom Form – Initial

Name _____

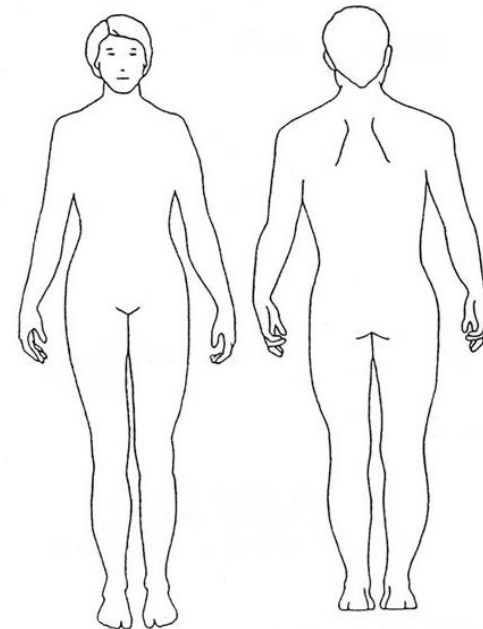
Date _____

Complaint	Area #1	Area #2	Area #3
How are you feeling today? 0 = no pain thru 10 = much pain			
Does the pain travel anywhere? Where?			
Date pain began?			
How did the pain begin?			
How often does it hurt?			
What makes the pain worse?			
What makes the pain less?			
What can't you do that you did before the pain started?			
Have you tried anything at home to relieve the pain?			
Have you seen any other Doctors for it? Who? When?			
What did Doctors Advise?			
Have you had this pain before? When?			

Pain Drawing

Please indicate the location of pain and the symbol that best describes the discomfort you are feeling.

Type of Pain	Symbol
Sharp / Stabbing	+++++++
Dull / Achy	VVVVV
Pins / Needles	OOOOO
Numbness	/ / / / /



Signature _____