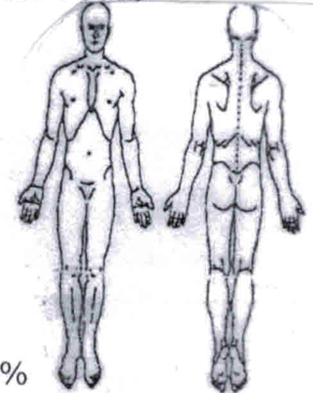
HEAD NECK & SPINE CENTER
OF SAN DIEGO

INITIAL HEALTH STATUS

PATIENT NAME: ______________________ BIRTHDATE: __________ SEX: M/F
ADDRESS: ______________________ CITY: ______________ STATE: _____ ZIP: ________
SSN: ____________ OCCUPATION: ______________ EMPLOYER: ______________
HOME PH: ______________ WORK PH: ______________ CELL: ______________
EMAIL ADDRESS: ______________________ HEALTH PLAN: ______________
SUBSCRIBER NAME: ______________ SUBSCRIBER ID #: ______________ GROUP #: ________
EMERGENCY CONTACT: ______________________ PH: ______________
Language Pref :______________ REFERRED BY: ______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

____

Is This? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: ______________________

Current Complaint (How You Feel Today):

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 75-100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe)______________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ NO ☐ YES **Date(s) Taken:** __________

What Areas Were Taken? ______________________________

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, #of Births___
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐G ☐L
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (Date)_______	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications:
☐	☐	Cancer/Tumor			______________
☐	☐	Osteoporosis			______________
☐	☐	Recent Trauma			______________

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

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________ **Date:** ______________