LUNDY HEALTHCARE AT THE BEACH **PATIENT HISTORY**

Name____ DOB _________________ Social Security # ___________________________

Martial Status S______ M______ D______ W______ Sep_____

Height: ___________Ft ___________ Weight ________________ lbs.

Address ____ City _________________________ST________ Zip _______________

Phone (H) ____________________________ (W) _________________________ (C) __________________________

Email ____ Can you receive text messages? ________ Yes ______No

Your Occupation _______________________ Employer ____

How did you hear about our office? (Circle One) Office Sign Yellow Pages Newspaper Website

If another person, whom? Family member ___________________ Friend___________________ Co-worker _______________________

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ____________

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: ____

Date when symptom first appeared ________________________ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ____________________________ What relieves the symptoms? ___________________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐ Numb/tingling Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ____________________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ______________________________

____

Do you have any family members who suffer from the same complaint? If so, who? ____________________________________

SECONDARY COMPLAINT: ____

Date when symptom first appeared ________________________ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? ____________________________ What relieves the symptoms? ___________________

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐ Numb/tingling Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐ yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) ____________________

Please list all previous treatments for this condition (give doctor's name and dates if possible) ______________________________

____

Do you have any family members who suffer from the same complaint? If so, who? ____________________________________

Do you smoke? ☐yes ☐no Have you ever smoked in the past? ☐yes ☐no

If yes, when did you quit? ___________________ Are you currently pregnant? ☐yes ☐no

Do you take birth control? ☐yes ☐no Have you ever taken birth control in the past? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? __________________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ___________________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ___________________

Do you have a high stress level? ☐yes ☐no If yes, list reasons: ____________________________

____

Please list any medications you are currently taking:

____

____

____

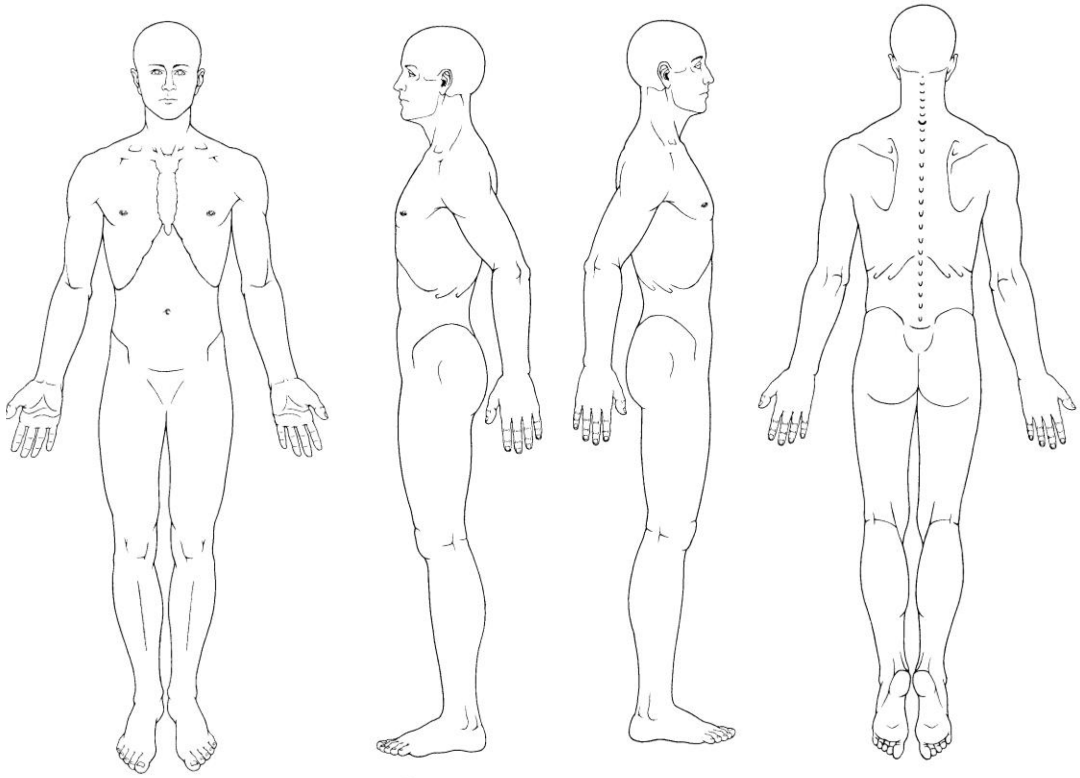
____

____

PATIENT SIGNATURE ____ **DATE** ____________________

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc with dates: ______________________________

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____

____

PLEASE CHECK IF YOU HAVE/HAD ANY OF THE FOLLOWING:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump	☐ Bronchitis
☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency	☐ Chicken Pox
☐ Diabetes	☐ Disc Degeneration/Herniation	☐ Emphysema	☐ Epilepsy	☐ Glaucoma/Macular Degeneration
☐ Goiter	☐ Gonorrhea	☐ Gout	☐ Heart Attack	☐ Heart Disease
☐ Hepatitis	☐ Hernia	☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Disease	☐ Liver Disease	☐ Measles	☐ Migraine	☐ Miscarriage
☐ Mononucleosis	☐ MS	☐ Mumps	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia	☐ Polio	☐ Prostate Problem
☐ Prosthesis	☐ Psychiatric Care	☐ Rheumatic Fever	☐ Rheumatoid Arthritis	☐ Scarlet Fever
☐ Stroke	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis	☐ Tuberculosis
☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease	☐ Vaginal Infections
☐ Venereal Disease	☐ Whooping Cough	☐	☐	
☐ Other				

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CERVICAL SPINE/NECK (Do you get head or neck pain?)-- ***These nerves send energy and strength to the brain, neck, thyroid etc.. Postural Distortions weaken these nerves and cause:***

☐ Neck Pain	☐ Pain in shoulders/arms/hands	☐ Numbness/tingling in arms/hands	☐ Weakness in grip	☐Coldness in hands (peripheral circulation)
☐ Headaches	☐ Visual disturbances (blurred/double vision, dry eyes)	☐ Hearing disturbances (ringing in the ears, frequent ear infections)	☐ Recent difficulty speaking?	☐ Dizziness/Vertigo (balance/coordination problems)
☐ Allergies/Hay fever/Sinusitis	☐ Recurrent Colds/Flu (Do you feel you are always getting sick?)	☐ Thyroid conditions	☐ Energy problems (not enough/slugginess/tired in afternoon)	☐ TMJ Pain/Clicking

THORACIC SPINE/UPPER BACK (Do you get pain between your shoulder blades or just below your neck?)-- ***These nerves send energy and strength to the muscles of the upper back, heart, lungs etc.. Postural Distortions weaken these nerves and cause:***

☐ Heart Palpitations	☐ Irregular Heart Beat	☐ Heart Murmurs	☐ Tachycardia/Bradycardia	☐ Angina
☐ High Cholesterol	☐ Recurrent Lung Infections	☐ Bronchitis	☐ Asthma	☐ Wheezing/Shortness of Breath
☐ Pain on Deep Inspiration	☐ High Blood Pressure	☐ Digestive gas (belching or passing gas)/Gallstones	☐ Shingles	☐ Rotator Cuff weakness/Frozen Shoulder

THORACIC SPINE/MID BACK (Do you get rib pain/flank pain?)-- ***These nerves send energy and strength to abdominal organs and rib cage. Postural Distortions weaken these nerves and cause:***

☐ Pain that traces around your body to the front	☐ Pain below your shoulder blades	☐ Indigestion/Heartburn	☐ Jaundice	☐ Ulcers/Gastritis
☐ Tired/Irritable After Eating or When not having eaten for a while	☐ Nausea	☐ Constipation	☐ Diarrhea	☐ Hypo/Hyperglycemia
☐ Colitis	☐ Diabetes	☐ Kidney Stones	☐ Chronic TB	☐ Portal Hypertension
☐ Stress Disorders	☐ Hives/Skin Conditions	☐ Diverticulosis/Diverticulitis	☐ Chron's Disease	☐ IBS

PATIENT SIGNATURE ______________________________ **DATE** ______________

LUMBAR SPINE/LOWER BACK PAIN (Do you get low back pain?)-- ***These nerves send energy and strength to the lower back, legs and pelvic organs. Postural distortion can weaken these nerves and cause:***

☐ Low back pain	☐ Pain in Butt/Hips/Legs/Feet	☐ Weakness or Injuries in Hips/Knees/Ankles	☐ Numbness and /or Tingling in Butt/Legs/Feet	☐ Coldness in the Legs or Feet
☐ Muscle Cramps in Legs/ Feet	☐ Recurrent Bladder Infections	☐ Frequent/Difficulty Urinating	☐ Difficulty Holding Urine (bladder weakness)	☐ Sexual Dysfunction
☐ Menstrual Irregularities/Cramping	☐ Prostate Problems	☐ Sciatica	☐ Bedwetting	☐ Long leg/Short leg
☐ Hemorrhoids	☐ Problems sitting/standing	☐ Infertility	☐ Frequent Groin Pulls	☐ Consistent Hamstring Tightness/Pain

Emergency Contact

Name: ____Phone Number: (_______) ________-___________

Address: __________________________

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____________

Employment Information – Job description **[] RETIRED [] DISABLED [] UNEMPLOYED**

Business Name: _____________________________________Occupation/Job Title: _______________________
Business Address: ___________________________________Name of Supervisor: ________________________

Business Phone: (____)_____-_______Type of Work:__________________ Work: ___hrs/day or___ per week

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs**)** ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)
Lifting Frequency: ☐ Constant **(67-100%/day)** ☐ Frequent (**33-66%/day)** ☐ Occasional **(0-32%/day)**

Insurance Information:

Who is responsible for your bill? YOU and… (Mark appropriate box (es)) ☐ **Myself ONLY** ☐ **Spouse**

☐ **Worker's Comp** ☐ **Auto Insurance [] Medpay claim** ☐ **Medicare** ☐ **Other (be specific):_____________**

Personal Health Insurance Carrier: _________________Health ID card #: ______________________________

Policy Holder's Name: ____________________________Group #: ____

Policy Holder's Social Security #: ______-_____-_______

Policy Holder's Birthday Date: ___________________

Primary Care Physician: ___________________________

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Workers Compensation Injury / Auto / Personal Injury ***Have you filed an injury report***
☐Yes ☐No

Carrier: ____ Policy # ________________________________

Carriers Phone #: (_______) ___________-____________ Adjuster: _______________________________

Claim #: ____ Date: ____/____/______Time: _______am/pm

Attorney name:________________________________ Attorney Phone #: (______) ________-____________

VITAMINS/HEALTH SUPPLEMENTS/ ADDITIONAL MEDICATIONS:
PLEASE LIST ANY VITAMIN OR HEALTH SUPPLEMENTS YOU INGEST ON A REGULAR BASIS

_______________________________________ ____

_______________________________________ ____

_______________________________________ ____

HEALTH GOALS: WHY YOU ARE REALLY HERE. Please list the activities/hobbies/daily tasks you either want to be able to do again without pain or perform better. Ex: lose a certain number of pounds, walk around The Loop, play golf again, work pain-free etc….

1)____

2)____

3)____

4)____

PAYMENT IS DUE AS SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. IF YOU ARE UTILIZING HEALTH INSURANCE, PLEASE REALIZE THE AGREEMENT YOU SIGNED WITH YOUR HEALTH CARE CARRIER IS BETWEEN YOU AND THAT CARRIER, NOT BETWEEN THIS OFFICE AND YOUR HEALTH CARE CARRIER. ALTHOUGH WE WILL DO WHAT WE CAN TO ASSIST YOU, YOU ARE ULTIMATELY PERSONALLY RESPONSIBLE FOR YOUR BILL IN THIS OFFICE.

PATIENT SIGNATURE ____ **DATE** ____________________

NECK PAIN QUESTIONNAIRE

Patient Name: ______________________________ **Date:** ____________________

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

Pain Intensity 0 I have no pain at the moment. 1 The pain is very mild at the moment. 2 The pain is moderate at the moment. 3 The pain is fairly severe at the moment. 4 The pain is very severe at the moment. 5 The pain is the worst imaginable at the moment.	***Concentration*** 0 I can concentrate fully when I want to with no difficulty. 1 I can concentrate fully when I want to with slight difficulty. 2 I have a fair degree of difficulty in concentrating when I want to. 3 I have a lot of difficulty in concentrating when I want to. 4 I have a great deal of difficulty in concentrating when I want to. 5 I cannot concentrate at all.
Personal Care (Washing, Dressing, etc.) 0 I can look after myself normally without causing extra pain. 1 I can look after myself normally, but it causes extra pain. 2 It is painful to look after myself and I am slow and careful. 3 I need some help, but manage most of my personal care. 4 I need help every day in most aspects of self care. 5 I do not get dressed, I wash with difficulty and stay in bed.	***Work*** 0 I can do as much work as I want to. 1 I can only do my usual work, but no more. 2 I can do most of my usual work, but no more. 3 I cannot do my usual work 4 I can hardly do any work at all. 5 I cannot do any work at all.
Lifting 0 I can lift heavy weights without extra pain. 1 I can lift heavy weights, but it gives extra pain. 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 4 I can lift very light weights. 5 I cannot lift or carry anything at all.	***Driving*** 0 I can drive my car without any neck pain. 1 I can drive my car as long as I want with slight pain in my neck. 2 I can drive my car as long as I want with moderate pain in my neck. 3 I cannot drive my car as long as I want because of moderate pain in my neck. 4 I can hardly drive at all because of severe pain in my neck. 5 I cannot drive my car at all.
Reading 0 I can read as much as I want to with no pain in my neck. 1 I can read as much as I want to with slight pain in my neck. 2 I can read as much as I want to with moderate pain in my neck. 3 I cannot read as much as I want because of moderate pain in my neck. 4 I cannot read as much as I want because of severe pain in my neck. 5 I cannot read at all.	***Sleeping*** 0 I have no trouble sleeping. 1 My sleep is slightly disturbed (less than 1 hour sleepless). 2 My sleep is mildly disturbed (1-2 hours sleepless). 3 My sleep is moderately disturbed (2-3 hours sleepless). 4 My sleep is greatly disturbed (3-5 hours sleepless). 5 My sleep is completely disturbed (5-7 hours)
Headaches 0 I have no headaches at all. 1 I have slight headaches which come infrequently. 2 I have moderate headaches which come infrequently. 3 I have moderate headaches which come frequently. 4 I have severe headaches which come frequently. 5 I have headaches almost all the time.	***Recreation*** 0 I am able to engage in all of my recreational activities with no neck pain at all. 1 I am able to engage in all of my recreational activities with some pain in my neck. 2 I am able to engage in most, but not all of my recreational activities because of pain in my neck. 3 I am able to engage in a few of my recreational activities because of pain in my neck. 4 I can hardly do any recreational activities because of pain in my neck. 5 I cannot do any recreational activities at all.

PATIENT SIGNATURE ______________________________ **DATE** ____________________

LUNDY HEALTHCARE AT THE BEACH **PATIENT HISTORY**

LOW BACK PAIN QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________________

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

Standing

0 I can stand as long as I want without pain.
1 I have some pain while standing, but it does not increase with time.
2 I cannot stand for longer than one hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than ten minute without increasing pain.
5 I avoid standing, because it increases the pain straight away.

Personal Care

0 I would not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increases the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain, I am unable to do some washing and dressing without help.
5 Because of the pain, I am unable to do any washing or dressing without help.

Sleeping

0 I get no pain in bed.
1 I get pain in bed, but it does not prevent me from sleeping well.
2 Because of pain, my normal night's sleep is reduced by less than one than one quarter.
3 Because of pain, my normal night's sleep is reduced by less than one-half.
4 Because of pain, my normal night's sleep is reduced by less than three-quarters.
5 Pain prevents me from sleeping at all.

Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights, but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights, at the most.

Social Life

0 My social life is normal and gives me no pain.
1 My social life is normal, but increases the degree of my pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
3 Pain has restricted my social life and I do not go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

Walking

0 Pain does not prevent me from walking any distance.
1 Pain prevents me from walking more than one mile.
2 Pain prevents me from walking more than 1/2 mile.
3 Pain prevents me from walking more than 1/4 mile.
4 I can only walk while using a cane or on crutches.
5 I am in bed most of the time and have to crawl to the toilet.

Traveling

0 I get no pain while traveling
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling which compels me to seek alternative forms of travel.
4 Pain restricts all forms of travel.
5 Pain prevents all forms of travel except that done lying down.

Sitting

0 I can sit in any chair as long as I like without pain.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting more than one hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than ten minutes.
5 Pain prevents me from sitting at all.

Changing Degree of Pain

0 My pain is rapidly getting better.
1 My pain fluctuates, but overall is definitely getting better.
2 My pain seems to be getting better, but improvement is slow at present.
3 My pain is neither getting better nor worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

PATIENT SIGNATURE ______________________________ **DATE** ______________

Lundy Healthcare
at The Beach

ASSIGNMENT OF BENEFITS FOR INSURANCE AND PERSONAL INJURY PATIENTS

IN CONSIDERATION of the willingness of Lundy Healthcare at the Beach to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I hereby authorize and instruct you to pay directly to Lundy Healthcare at the Beach, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Lundy Healthcare at the Beach for its services rendered.

I authorize Lundy Healthcare at the Beach to release to any insurer with applicable coverage or to my attorney any information regarding my injuries, prior medical history or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Lundy Healthcare at the Beach for services rendered, including any balance remaining after the application of insurance payments and settlements or judgment proceeds. If Lundy Healthcare at the Beach is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Lundy Healthcare at the Beach for its cost of recovery, including reasonable attorney fees.

Lundy Healthcare at the Beach

Representative: ________________________________

Witness ________________________________

PATIENT SIGNATURE ____ **DATE** ____________________