Patient Name:_____ Date:_____ Email:_____

SS #/SIN:_____-_____-_____ DOB:_____ Home phone:_____ Cell Phone:_____

Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated Gender: □ Male □Female

Patient's Address:_____ City:_____ State:_____ Zip:_____

Employer Name (if applicable):_____

Spouse or Guardian name:_____ Spouse's Employer:_____

Person to contact in case of an emergency:_____ Relationship:_____ Phone:_____

Name of the person responsible for this account:_____ Relationship to Patient:_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent / Guardian: _____ Date:_____

Primary Care Phys.: _____ Clinic:_____ Phone:_____

Cardiologist *(If Applicable)*:_____ Clinic:_____ Phone:_____

Do you have an Advanced Directive? Yes / No **(If Yes, please provide a copy) Circle applicable for emergency:** DNR / Full Code

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Compass Medical Center** (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or services provided after my insurance company(s) have determined my benefits. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____ _____

Patient Signature Print Name Date

Health History:

Chief Complaint: _____

History of Present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal vs abnormal color, activity, etc..)

Severity: _____ (How severe is the pain/problem on a scale of 1-10)

Duration: _____ (How long have you had this pain/ problem?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (When did the pain/problem start?)

Signs/Symptoms: _____ (What associated problems have you been having?)

Modifying Factors: _____ (What makes the pain/problem worse or better?)

Have you had previous Tx for this condition:_____ (What providers have you seen?)

Outcome: _____ (Did this help your current condition?))

Anything else tried to handle this: _____ (What other tx options have you tried?)

Outcome: _____ (Did this help your current condition?)

Medication: (include non-prescription / vitamins): _____

_____

Are you taking any medications (prescription or over the counter) for acid indigestion? O yes O no If yes, what type:_____

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Allergies:_____

Past Medical History:

Please list any **diseases, illnesses, diagnosed disorders, and implanted devices** (*such as Cancer, Diabetes, Heart disease, Hypothyroidism, Autoimmune disease, Parkinson's disease, Rheumatoid Arthritis, pacemaker, ect…*)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations / Surgeries / Accidents	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age:	Disease(s):	If Deceased, Cause Of Death:
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes / Ears / Nose / Throat / Respiratory		**Muscular / Skeletal**		**Neurological**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Tingling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5		
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5	**General**	
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Fatigue	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Irritability	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5	Constipation	1 2 3 4 5
Wheezing	1 2 3 4 5			Diarrhea	1 2 3 4 5
				Feeling foggy	1 2 3 4 5
				Forgetfulness	1 2 3 4 5

Have you experienced any falls? Yes / No Were you hospitalized or treated for this incident? Yes / No What was the intervention? _____

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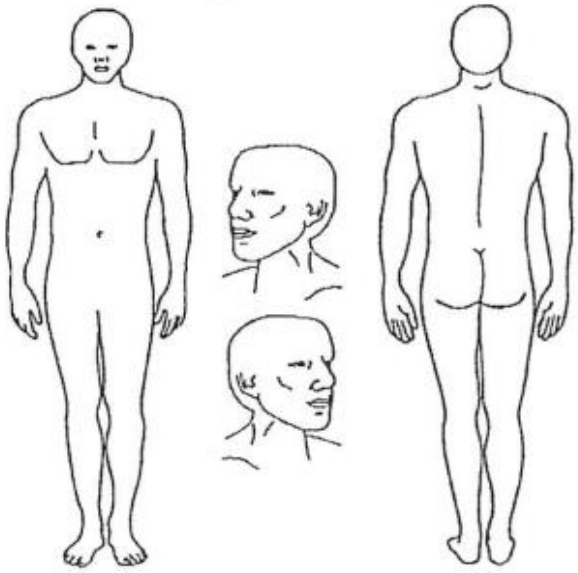
PROGRESS REPORT



PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

A = SHARP PAIN
B = DULL PAIN
C = BURNING PAIN
D = NUMBNESS
E = TINGLING

Please Mark the intensity of pain you are experiencing on the pain scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild		Discomforting		Distressing		Horrible			Excruciating

Daily Activities:	**Effects of Current Condition on Performance:**			
1.) Bending:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
2.) Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
3.) Changing Position:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
4.) Climb Stairs:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
5.) Driving:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
6.) Ext Computer Use:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
7.) Household Chores:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
8.) Kneeling:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
9.) Lift Children:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
10.) Lifting:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
11.) Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
12.) Self-Care (Bathing):	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
13.) Self-Care (Dressing):	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
14.) Self-Care (Shaving):	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
15.) Sexual Activities:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
16.) Sleep:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
17.) Sitting:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
18.) Standing:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
19.) Walking:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
20.) Yard Work:	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
21.) Other_____	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)
22.) Other_____	☐ No Effect	☐ Mild Painful (Can Do)	☐ Mod. Painful (Limited)	☐ Sev. (Unable to Do)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____

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Patient Signature	Print Name	Date
_____	_____	_____
Doctor Reviewing Signature	Print Name	Date