Glen Bobker, D.C., P.A.
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P: 954-463-1166 / F: 954-522-6836

PATIENT INFORMATION

PATIENT NAME

Last Name _____ First Name _____ Middle _____

Gender: M F Date of Birth ____ / ____ / ____ Age _____ _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer Name _____ Phone _____

Employer Address _____

City _____ State _____ Zip _____

SPOUSE OR GUARDIAN

Last Name _____ First Name _____ Middle _____

Employer Name _____ Phone _____

Date of Birth ____ / ____ / ____ _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relation to Patient _____

PAYMENT METHOD For all services that are not paid by a third party.

☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ _____
Signature of patient or person acting on patient's behalf Date

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MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____
Signature of patient or person acting on patient's behalf Date

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MEDICAL AND HEALTH HISTORY

Date _____ Patient Name _____ Date of Birth _____

Main Problem

What pain causes you to come to the office?_____

What caused this pain? _____

When did this pain start? _____ How long does this pain last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Carmping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,
Lighteninglike, Throbbing, Nagging, Burning Deep, Stinging, Pressurelike

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Carmping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,
Lighteninglike, Throbbing, Nagging, Burning Deep, Stinging, Pressurelike

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other History

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Do you drink? ☐ Yes ☐ No If yes, how much?_____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _____

Are you pregnant? ☐ Yes ☐ No Date of last physical exam _____

Are you employed ? ☐ Yes ☐ No Where _____

How is your overall health? _____

List past illnesses _____

_____

Surgeries / Hospitalizations / Injuries	Medications	Purpose

(Use other side if necessary)

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P.A.R.T. DOCUMENTATION

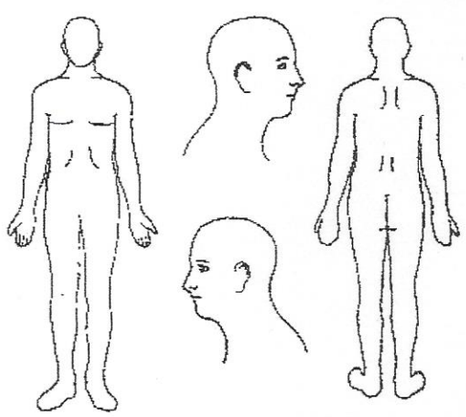
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today?_____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X_____