Jennifer Feeney, D.C.

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION

FULL NAME___________________________________ DATE OF BIRTH____/____/____ AGE____ MALE □ FEMALE □

ADDRESS____ APT#____ SSN_____-_____-_____

CITY__________________________ STATE____ ZIP CODE __________ HOME PHONE (____)__________________

ALTERNATE PHONE (____)___________ EMAIL ADDRESS ____

EMPLOYER'S NAME_________________________________ OCCUPATION___________________________________

WORK ADDRESS____________________________________ CITY_____________ STATE ____ZIP CODE__________

WORK PHONE (____)________________ EXT_______ MARITAL STATUS: SINGLE □ MARRIED □ WIDOWED □

EMERGENCY CONTACT ___________________________________ PHONE_________________________________

DATE SYMPTOMPS BEGAN___/___/___ HOW DID YOU HEAR ABOUT US? __________________________________

PRIMARY CARE PHYSICIAN __________________________________PHONE________________________________

CLAIM INFORMATION

IS YOUR CONDITION DUE TO: AN AUTO ACCIDENT □ A PERSONAL INJURY □ A WORK INJURY □ OTHER □

TYPE OF CLAIM: CASH □ GROUP HEALTH INS □ PERSONAL INJURY □ WORKER'S COMP □ MEDICARE □

I WILL BE PAYING BY: CASH □ CHECK □ VISA □ MASTERCARD □ AMEX □ DISCOVER □ OTHER □

INSURANCE INFORMATION

RELATIONSHIP TO INSURED? SELF □ SPOUSE □ OTHER □ CHILD □ SPOUSE:________________________

INSURED'S EMPLOYER: SAME AS ABOVE □ ____

INSURED'S SSN: SAME AS ABOVE □ SSN____-____-____ INSURED'S DOB: SAME AS ABOVE □ ____/____/____

PRIMARY INSURANCE CO. ___________________________ ADDRESS ____________________________________

CITY____________________________________ STATE____ ZIP CODE __________ PHONE ____________________

POLICY NUMBER ___________________________________ GROUP NUMBER_______________________________

SECONDARY INSURANCE CO. ________________________ ADDRESS ____________________________________

CITY____________________________________ STATE____ ZIP CODE __________ PHONE ____________________

POLICY NUMBER ___________________________________ GROUP NUMBER_______________________________

AUTHORIZATIONS

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefit submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient/Guardian's Signature:____Date:_____________________

2020 Norwich-New London Turnpike, Suite 9
Uncasville, CT 06382
PHONE (860) 892-8122
FAX (860) 892-8151

Jennifer Feeney, D.C. — Confidential Patient History

Patient: ______________________ DOB:__________ DOI:__________ Date:__________

Chief Complaint

What brings you in the office? ______________________________

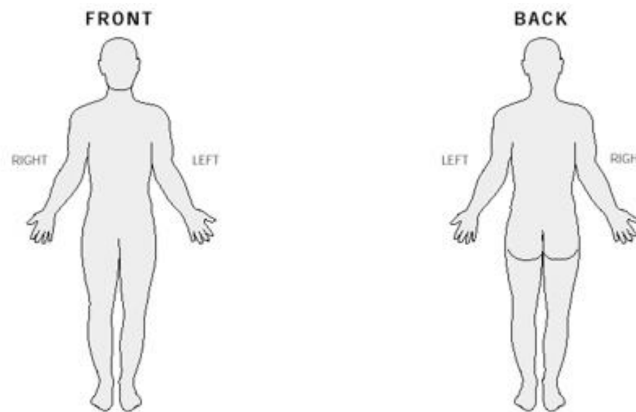
Present Illness

Onset: What was the date of injury? Or when did you become aware of the symptoms? ______________

Mechanism: How did the injury occur? ______________________________

Recurrence: Have you had this pain before? YES or NO Describe ______________________

Location: Mark the areas on the diagram where you feel discomfort.



Radiation: Does the symptoms radiate into the arms or legs? □ YES □ NO

Quality: Describe the type of pain.

□Sharp	□Shooting	□Throbbing	□Stiffness	□Dull	□Aching
□Burning	□Tingling	□Numbness	□Cramps	□Swelling	□ Other

Severity: Please mark a line on the scale to describe your level of discomfort. If you are describing more than one symptom, indicate the level of pain for each symptom.

No Pain | ______________________________ | **Worst possible pain**

Duration/Freq: How long do your symptoms last? ____________How often to you experience your symptoms?__________

Temporal: Is your pain worst during any particular part of day or night? ______________________

Provocative: What activities or conditions seem to make your symptoms worse? ______________________

Palliative: What tends to make you feel better? ______________________________

Other Provider: Name and phone number of any health care provider who has seen you for this condition. Including X-rays/MRI.

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Patient: ______________________ DOB:__________ DOI:__________ Date:__________

Past Medical History

Please circle to indicate if you have any of the following:

AIDS/HIV	Cancer	Gout	Multiple Sclerosis	Stroke
Alcoholism	Cataracts	Heart Disease	Mumps	Suicide Attempt
Anemia	Chicken Pox	Hepatitis	Osteoporosis	Thyroid Problems
Anorexia	Diabetes	Hernia	Pacemaker	Tonsillitis
Appendicitis	Drug Abuse	Herpes	Pneumonia	Tuberculosis
Arthritis	Emphysema	High Cholesterol	Polio	Tumors
Asthma	Epilepsy	Kidney Disease	Prostate Problem	Ulcers
Blood Disorders	Fractures	Liver Disease	Psychiatric Care	Vaginal Infections
Breast Lump	Glaucoma	Measles	Rheumatic Arthritis	Venereal Disease
Bronchitis	Goiter	Migraines	Rheumatic Fever	Whooping Cough
Bulimia	Gonorrhea	Mononucleosis	Scarlet Fever	Other

Surgeries	Description	Date
	______________________	__________
	______________________	__________
	______________________	__________

Medications	Allergies	Vitamins/Herbs/Minerals
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________

Family History

Please circle if you have your immediate family members that have any of the following:

Emphysema	Diabetes	Stomach	Mental Illness	Osteoporosis
Headaches	Circulation Problems	Ulcers	Alcoholism	Liver Disease
Heart Disease	AIDS/HIV	Back Problems	Arthritis	Cancer
High Blood Pressure	Seizures-Convulsions	Kidney Disease	Stroke	Thyroid Disease

What was the cause of death? ______________________________

Activities of Daily Life

Please rate your difficulties in performing the activities below. (0 No difficulties – 5 Cannot perform due to pain)

Difficulties with self care and personal hygiene	0	1	2	3	4	5
Difficulties with physical activities (standing/sitting/bending)	0	1	2	3	4	5
Difficulties with functional activities (lifting/pushing)	0	1	2	3	4	5
Difficulties with social or recreational activities	0	1	2	3	4	5
Difficulties with traveling (driving/flying)	0	1	2	3	4	5

Please rate how your condition has affected your senses below. (0 No change – 5 Loss of ability)

Difficulty with different forms of communication (reading/writing)	0	1	2	3	4	5
Difficulty with senses (smell/touch/taste/hearing/seeing)	0	1	2	3	4	5
Difficulty with hand function (grasping)	0	1	2	3	4	5
Difficulty with sleep and sexual function	0	1	2	3	4	5

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Review of Systems

Do you have or have you ever had:

- Any generalized changes in general health such as weakness, fatigue, fever, chills, night sweats, fainting, changes in sleep pattern, unexplained weight loss, unexplained weight gain or others?
  YES OR NO If yes, please explain______________________________
- Any skin problems such as rashes, itching, dryness, sores, changes in color, changes in moles, changes in hairs, changes in fingernails or others?
  YES OR NO If yes, please explain______________________________
- Any eye, ear, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in the ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others?
  YES OR NO If yes, please explain______________________________
- Any heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain cold extremities, high/lo blood pressure or others?
  YES OR NO If yes, please explain______________________________
- Any lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood or others?
  YES OR NO If yes, please explain______________________________
- Any gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, changes in appetite/thirst, changes in stools or other?
  YES OR NO If yes, please explain______________________________
- Any genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others?
  YES OR NO If yes, please explain______________________________
- Any musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others?
  YES OR NO If yes, please explain______________________________
- Any neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others?
  YES OR NO If yes, please explain______________________________
- Any psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others?
  YES OR NO If yes, please explain______________________________
- Any endocrine problems such as severe intolerance to heat or cold, changes in thirst, excessive sweating or others?
  YES OR NO If yes, please explain______________________________
- Any hematological problems such as anemia, diabetes, hepatitis, autoimmune disease or others?
  YES OR NO If yes, please explain______________________________

Is there anything else you think the doctor should know about your medical history?

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