REINFORCE HEALTH & WELLNESS

Patient Information

Name: ____________________ Date: __________

Date of Birth: ______________ □ male □ female

Marital status (circle)

S M W D Sep

Social Security #: ____________________

Address: ____________________

____

E-Mail: ____________________

Phone #: home: __________ cell: __________

Occupation: ____________________

Employer: ____________________

Emergency Contact:

Name: ____________________

Number: ____________________

Insurance Information

Insurance Co.: ____________________

Group #: __________ Policy #: __________

Primary Card Holder: ____________________

Birthdate of Insured: ____________________

Relationship to Patient: ____________________

Assignment and Release:

I certify that I, and/or my dependents, have insurance coverage with ______________ and assign directly to (Dr. David Kim / Dr. Lesley Wong) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use for my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

X: ____________________

Date: ____________________

Accident Information

Is the condition due to an accident? □ Yes □ No

Referred by: ____________________

Patient Condition

Give a breif detailed description of the problem you are currently experiencing: ____________________

____

How long have you had this condition? ______________ Is it getting worse? □ yes, □ no

Rate the severity of your pain on a scale from 1 (least pain) to 10 (worst pain) ______________

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Burning □ Aching

□ Shooting □ Tingling □ Cramping □ Stiffness □ Swelling □ Other

How often do you have this pain? ______________ Is it *constant* or does it *come and go*?

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you already received for your condition? ______________

Name and address of other doctor(s) who have treated you for your condition ______________

____

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Health History

Mark (c) for current problems, check and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Hearing loss
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Abdominal bloating
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Exercise:
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Heavy

Work Activity:
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Other Habits:
- ☐ Smoking — Packs/Day ____________
- ☐ Alcohol — Drinks/Week ____________
- ☐ Coffee/Caffeine — Cups/Day ____________
- ☐ Stress — Reason ____________

Are you pregnant? ☐ Yes ☐ No   If yes, due date ______________________

Injuries/Surgeries- Please describe major injuries and any surgical procedures performed: ______________________

____

Date of last: Physical Exam ____________ Spinal Exam ____________

Spinal X-ray ____________ Blood/Urine test ____________

MRI/CT/Bone Scan ____________