Sixth Borough MEDICAL

Demographics

Full Name: *

First Name Middle Name Last Name

Date of Birth: *

Month Day Year

Social Security Number:

Gender *

Male

Female

Mobile Phone Number: *

Area Code Phone Number

Home Number

Area Code Phone Number

Email: *

example@example.com

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Home Address: *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Emergency Contact Information

Martial Status

If Married: Name of Spouse

First Name Last Name

If Married: Cell Phone Number of Spouse

Area Code Phone Number

Name of Emergency Contact

First Name Last Name

Relationship to Patient:

Mobile Number

Area Code Phone Number

How did you hear about us?

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Insurance Information

Primary Insurance Carrier Name:

ie. Horizon

Primary Care Physician (Name, Contact Information)

Pharmacy Information (Name, Address, Phone)

Claim/ID#:

Group #:

Policy Holder Name:

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First Name Last Name

Relationship to Patient:

Policy Card Holder Date of Birth:

Month Day Year

Employment Information

Occupation

Name of Employer

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Work Number

Area Code Phone Number

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Accident Information

Fill out this section if you are being evaluated related to a Motor Vehicle Accident or a Work Related Injury

Is this appointment related to an accident sustained in a vehicle or work? *

Are you currently working?

To what extent are you working?

Last Day Worked:

Month Day Year

Did your accident occur during work hours?

Type of Accident

Accident Date:

Month Day Year

State in which accident occurred?

Attorney Information

Please include attorney name, contact

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Attorney Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Attorney's Phone Number

Area Code Phone Number

Attorney Fax Number:

Area Code Phone Number

Attorney Email:

example@example.com

Please provide a detailed description of your accident:

Name of Workers Compensation/Auto Injury Insurance Company

Claim or WCB#:

HISTORY OF PRESENT ILLNESS

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Areas of pain & symptoms

Brief history of your symptoms *

When did your symptoms begin? *

Month Day Year

Pain Scale *

	0	1	2	3	4	5	6	7	8	9	10	
No Pain												Severe Pain

Where on your body do you have discomfort?

	Left	Right	Both
Head			
Neck			
Mid-back			
Low back			
Shoulder			
Elbow			
Wrist			
Hand			
Chest			
Ribs			
Abdomen			
Pelvis			
Hip			
Knee			

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Ankle

Foot

Indicate Type of Discomfort:

	Yes	No
Sharp		
Stabbing		
Throbbing		
Dull		
Pressure		
Burning		
Stiffness		
Weakness		
Spasm		
Numbness/Tingling		

If other, please explain

Have you treated with other doctors for this problem?

Yes
No

If yes, where?

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Have you had any physical therapy for this problem?

Yes

No

If yes, where?

Have you had any radiological studies performed (MRIs, CT Scans or X-Rays)?

Yes

No

If yes, please explain?

Include information what study was performed, which body part, date performed, and where it was performed

Past Medical/Surgical/Social History

Medical Problems - Please check all that apply

No active or past medical history

Neck or Back Pain

Osteoarthritis

Osteoporosis

Neck or Back Disc Disease

Rheumatoid Arthritis

Psoriatic Arthritis

Spinal Fracture

Headaches/Migraines

Diabetes

High Blood Pressure

Heart Disease

Stroke/CVA

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Hemiplegia
Blood Clots
Heart Failure
Chest Pain
Heart Attack (Myocardial Infarction)
Peripheral Vascular Disease
Thyroid Disease
Asthma
COPD
Pneumonia
Tuberculosis
COVID-19
Anemia
Bleeding Disorders
Cancer
Depression
Bipolar Disorder
Substance Abuse
Sleep Apnea
Chronic UTI
GERD
Irritable Bowel Syndrome
Lupus/SLE
Immune Disorder
Head Injury (TBI/Concussion/CTE)
Paralysis
Cerebral Palsy
Dementia
Alzheimer's Disease
Parkinson's Disease
Seizure Disorder
HIV/AIDs
MRSA
Hepatitis
Fibromyalgia
Kidney Disease
Prior Gun Shot

Past surgeries and procedures - Please check all that apply

No prior surgeries or procedures

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Nerve Injections
Joint Injections
Facet Injections
Epidural Injections
Discectomy
Spinal Fusion
Kyphoplasty/Vertibroplasty
Knee Replacement
Knee Arthroscopy
Shoulder Arthroscopy
Hip Arthroscopy
Hernia Repair
Gallbladder Removal
Implanted Defibrillator
Cardiac Stent
Heart Valve Implants
Metal Implants

If other medical or surgical history, please include here

Are you on any blood thinners?

If yes, please specify:

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Medications (Please include supplements):

Please include Name Dose and Frequency

Allergies

- No Known Drug Allergies
- IV dye/contrast
- Iodine
- Shellfish
- Penicillin
- Sulfa- drugs
- Erythromycin
- Ibuprofen
- Aspirin
- Cipro
- Latex
- Adhesive

Please explain what type of reaction you have? If other please explain

Social History

Do you drink Alcohol excessively?

Do you use Illicit Drugs?

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If Yes, please explain:

Do you use Tobacco? *

If Yes, clarify which form of tobacco

Pregnant *

Yes

No

Family History

Does anyone in your immediate family diagnosed with the following:

- Hypertension
- Diabetes
- Heart Disease
- Cancer
- Nerve or Muscle Disease
- Fibromyalgia
- Depression
- Bipolar Disorder
- Substance Abuse

If other please list or elaborate on the above.

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