REACTIVATION

Patient Information

Name _____ Date_____ Address _____
Home phone _____ Work phone _____ Email _____
Your employer _____Occupation_____
Type of claim: Cash Group Health Insurance Personal Injury Worker's Comp Medicare

Primary *–please present card to receptionist.*

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____

Secondary *–please present card to receptionist.*

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____

1. Please circle all of the following conditions you have now.

Anxiety	Confusion	Fever (Recent)	Memory Loss
Abdominal Pain	Concussion	Frequent Illness	Menstrual Discomfort
Appetite Change	Constipation (Excess)	Heartburn	Mood Swings
Bed-Wetting	Diarrhea (Excess)	Hernias	Nervousness
Black Tarry Stools	Difficulty Breathing	Impotence	Poor Circulation
Blurred Vision	Difficulty Hearing	Incontinence	Ringing In Ears
Breast Lumps Or Pain	Difficulty Seeing	Insomnia	Skin, Hair Or Nail Changes
Bruise Easy	Difficulty Swallowing	Light Sensitivity	Sinus Trouble
Chills	Dizziness	Loss Of Balance	Swelling
Cold Feet	Enlarged Glands	Loss Of Bowel Control	Urination Painful/Frequent
Cold Hands	Face Flushed	Loss Of Smell	Vomiting (Recent)
Cold Sweats	Fainting	Loss Of Taste	Weight Change
Concentration Loss	Fatigue (Recent)		

2. Have you had a major health crisis identified/ diagnosed? Please identify any general health concerns that you are having currently and what care you have been receiving.

_____
_____
_____
_____

Essence Of Wellness.com

1. Please list your main health objectives or chief complaints.

_____

When did you first notice this?_____Describe what the condition feels like_____

What do you do for relief? _____

2. When are your symptoms worse? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Always the same

_____

3. How did your complaint(s) begin? ☐Unknown ☐Suddenly ☐Gradually

_____

4. Check all the appropriate descriptions.

The sensations I feel are:

Pain	Numbness	Tingling	Stiffness	Soreness	Swelling
☐	☐	☐	☐	☐	☐

The quality of the pain is:

Burning	Dull	Sharp	Shooting	Aching	Throbbing
☐	☐	☐	☐	☐	☐

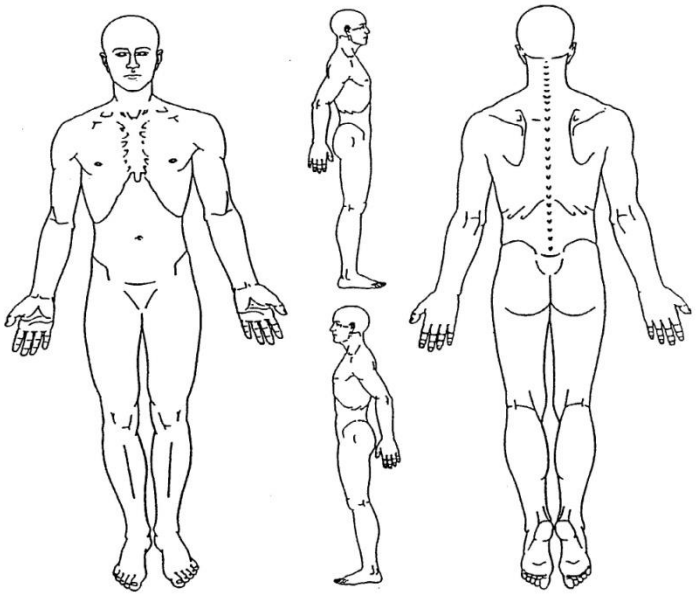
The pain duration is:

Occasional	Intermittent	Frequent	Constant
☐	☐	☐	☐

My condition is:

Improving	Worsening	Unchanged	Resolved
☐	☐	☐	☐

5. Indicate on the diagram where you have your complaints.



6. Mark what makes your condition Better or Worse?

☐B ☐W	☐B ☐W	☐B ☐W
☐ ☐ Bending	☐ ☐ Looking Down	☐ ☐ Rest
☐ ☐ Exercise	☐ ☐ Lying Down	☐ ☐ Sitting
☐ ☐ Heat	☐ ☐ Medication	☐ ☐ Standing
☐ ☐ Ice	☐ ☐ Nothing	☐ ☐ Stretching
☐ ☐ Lifting	☐ ☐ Pull/Pushing	☐ ☐ Twisting
☐ ☐ Looking Up	☐ ☐ Reaching	☐ ☐ Walking
☐ **Laughing**	☐ **Coughing**	☐ **Straining At Stool**

7. Have you noticed a change in?

☐ Bowel Function ☐ Bladder Function ☐ Coordination
☐ Sexual Function ☐ Muscular Strength

8. On a scale of 0- 10 rate the severity of your pain today.

If your pain fluctuates please indicate approximately the % of time at each pain level. *Example* 0 1 2 ③ 4 5 6 7 ⑧ 9 10

							70%			30%
	No Pain									Worst Pain Possible
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

9. What happened to cause or re-aggravate your complaint(s)?

☐Cause Unknown ☐Auto Accident ☐Personal Injury
☐Work Injury ☐Home Accident ☐Sport Injury
☐Other – Describe: _____

10. Please circle all areas of previous or current complaints or injuries.

Neck	Uppr back	Mid Back	Low Back	Shoulder	Arm	Elbow	Forearm	Wrist
Hand/Finger	Buttock	Hip	Thigh	Knee	Leg/Calf	Ankle	Foot	Others:

_____