Mercy

Welcome

Date: _____

Patient Information

Patient: _____ Preferred Name: _____

Address: _____ City, State, Zip: _____

Preferred Contact Number: _____ Can a message be left: ☐ Yes ☐ No

Email: _____

Birthdate: _____ Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Sex: ☐ Male ☐ Female Do you smoke? ☐ Yes ☐ No

Are you currently Pregnant? ☐ Yes ☐ No Due Date: _____

Have you had any in the last year: falls/broken bones? List:

_____

_____

Medications: _____

_____

Allergies: _____

Vitamins/Herbs/Minerals: _____

_____

Do you need an interpreter, sign language, have difficulty hearing or reading?	☐ Yes	☐ No
Do you have any questions regarding your nutrition?	☐ Yes	☐ No
Do you have an advanced beneficiary (living will)?	☐ Yes	☐ No
Do you require a cane, walker or wheelchair?	☐ Yes	☐ No
Do you have difficulty understanding verbal directions or explanations?	☐ Yes	☐ No
Do you have any religious or cultural practices that should be included in your case?	☐ Yes	☐ No

Whom may we thank for referring you?

_____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone #: _____

Accident Information

Is this condition due to an accident?

☐ Yes ☐ No Date: _____

Type of accident :

☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer

☐ Worker Comp. ☐ Other

Attorney Name (if applicable):

_____

Patient Condition

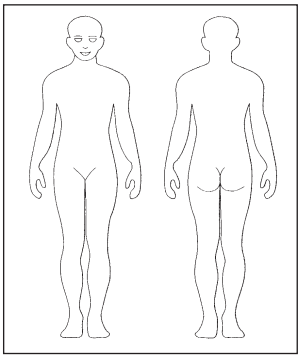
Reason for Visit: _____

_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ 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

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

Is someone hurting you? ☐ Pushed, slapped, choked, or kicked you ☐ Smashed or thrown things
☐ Made threats to you ☐ Put you down ☐ Humiliated you ☐ Forced you to have sexual contact
☐ Withheld money or medication