Health & Wellness Center PSL
433 NW Prima Vista Blvd., Port St. Lucie, FL 34983
Phone: (772) 336-1770 Fax: (772) 336-1160

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

Date_____ **Who may we thank for referring you** _____

Last Name_____ **First**_____ **Middle initial**____

Gender ○**Male** ○**Female** **Social Security number**_____ **Birth Date**_____

Marital Status ○**Single** ○**Married** ○**Divorced** ○**Widowed** ○**Separated** ○**Partnered**
Address

_____

City_____ **State**_____ **ZIP/Postal Code**_____

Home Phone_____ **Cell Phone**_____

_____ _____
Emergency Contact **Phone**

I give permission to be contacted by: ○ **Phone** ○ **Mail** ○ **Email** **(check all that apply)**

Occupation_____

Your Employer_____ **Work Phone**_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ **and assign directly to Health & Wellness Center/Dr. Lare Ziemba or Dr. Chris Snyder, 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 of my signature on all insurance submissions. This office may use my health care information and may disclose such information to the above-named insurance company(ies) 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 or one year from the date signed below. A copy of our office HIPPA form is available at your request.**

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

DATE:_____ **Relationship to Patient**_____

Name:_____ **Date**_____

1. The symptoms /pain that have prompted me to seek care today include:_____

_____

2. And are the result of ○ An accident ○ Work ○ Auto ○Other _____
○**A worsening long-term problem EXPLAIN:** _____

3. How long have you had your current symptoms? ○ Days ○ Weeks ○ Months ○ Years

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

5. Duration and Timing ○ Constant ○ Comes and goes ○ Occasional ○ Varies with activity
Explain?_____

6. Quality of symptoms (What does it feel like?) ○ Numbness ○ Tingling ○ Stiffness ○ Dull ○ Aching
○ Cramps ○ Nagging ○ Sharp ○ Burning ○ Shooting ○ Throbbing ○ Stabbing ○ Other_____

7. Radiation (Does it affect other areas of your body? (To what areas does the pain radiate, shoot or travel? Arm, leg, hand, head etc.)_____

8. Aggravating factors (What worsens the problem?) (Mark *all that apply*) ○ Sitting ○ walking ○ bending
○ sleeping ○ lifting ○ movement ○ household chores ○ exercise ○ driving ○ shopping ○ dressing
○ reaching ○ yard work ○ other:_____

9. Relieving factors (What tends to lessen the problem) (Mark *all that apply*) ○ Sitting ○ standing
○lying down ○ rest ○ no movement ○ stretching ○ ice ○ heat ○ medication ○ massage ○ topical ointment
○ other:_____

10. Prior interventions (What have you done to relieve the symptoms?) ○ Prescription medication
○ Surgery ○ Ice ○ Heat ○ Over the counter drugs ○ Homeopathic remedies ○ Physical therapy
○ Acupuncture ○ Massage ○ Chiropractic ○ Other :_____

11. Have you had an x-ray, MRI, CT Scan on your back or neck ○ No ○ Yes Date_____
What was found on the test?_____

12. Does your current condition interfere with: ○ Work ○ Recreational Activities ○ Household Responsibilities
○ Personal relationships ○Sports/ golf ○ Other:_____

13. Have you had any past injuries/ falls/ or accidents? Describe and injuries involved_____

_____

<u>Previous/ Other Health Care Providers you have seen in the last 5 years:</u>

Name of Provider	**Type of Physician**	**Problem seen for**	**still seeing**
_____			**Yes / No**
_____			**Yes / No**

Are you interested in nutritional counseling for weight loss or other conditions? [ ] Yes [ ] No