SOFT TISSUE CENTER
at
DIAGNOSTIC AND INTERVENTIONAL SPINAL CARE
softtisssuecenter.com

Name ____

Address ____

City ______________________________________ State__________

Zip __________________ Date of birth ________/________/________

Home telephone # ______________________________
Work telephone # ______________________________
Cellular phone#________________________________
E-mail address ________________________________
Social security # ______________________________

Marital status : single _____ married _____ widowed _____ divorced _____
domestic partner_____ separated______

Insurance company

____

Policy # ______________________________________

Group # ____________________________

Relationship to insured : self _____ spouse _____
dependent _____

If spouse or dependent: Insured's name

____

Insured's social security #

____

Area of complaint ____
____
____

Did this injury occur at work and is a workman's compensation case? _______________

Did this injury occur as the result of an automobile accident or other accident, and if so, is this a personal injury case? ________________

13160 Mindanao Way, Suite 308, Marina Del Rey, CA 90292
301 Bayview Circle, Suite 200, Newport Beach, CA 92660
Phone (310) 574-0395 Fax (310) 574-0394

Have you ever been hospitalized before? _______

If yes, when and for what reason ?____
____

Occupation____

What exercises do you perform? (or what sport do you participate?)
____
____

Who was your referral source?____

Name and telephone # of someone to contact in case of an emergency
Name _________________________________ Phone ___________________

Are you seeing any other physician of any type, for any reason? ___________
If yes, who? ____

In the following space, please place "1' for "have now", and "2" for "had", and leave the space blank for "never had".

_____ heart attack
_____congestive heart failure
_____high blood pressure
_____stroke
_____cough up phlegm
_____pneumonia
_____seizures
_____kidney stones
_____currently pregnant
_____vaginal discharge
_____breast soreness
_____prostate disorders
_____tuberculosis
_____liver disease
_____irritable bowel syndrome
_____smoke cigarettes
_____large weight gain / loss
_____hepatitis
_____allergies
_____rheumatic fever
_____measles
_____mumps
_____whooping cough
_____herpes simplex
_____genital herpes
_____dizziness
_____fainting
_____rapid heart rate
_____chronic cough
_____eye strain
_____visual disturbances
_____painful urination
_____kidney disease
_____birth control pills
_____menopause problems
_____osteoporosis
_____cancer
_____diabetes
_____ulcer
_____heartburn
_____hernia
_____intestinal disease
_____blood in stools
_____hemorrhoids
_____scarlet fever
_____chicken pox
_____Epstein-Barr virus
_____chronic fatigue syndrome
_____venereal disease
_____night pain

In the following space, please place "1' for "have now", and "2" for "had", and leave the space blank for "never had".

_____arthritis
_____history of gout in family
_____low back pain
_____neck pain
_____headaches
_____pain or tingling radiating down to arm and/or hand
_____pain between, under, or around shoulder blades
_____pain or tingling radiating down leg and /or foot
_____pain in hip
_____pain in knees
_____pain in ankles
_____pain in feet
_____pain in shoulders
_____pain in elbows
_____pain in wrists
_____pain in hands
_____any other pain? If so, please explain ____
____

Current medication: ____
____

What are your expectations from treatment?
____
____

Please identify whom you allow us to communicate with regarding your health/condition for HIPAA compliance (please specify by name):
Parents:____
Spouse:____
Friends/significant others:____
Children/family members:____
Coaches:____
Athletic Trainers:____
Personal Trainers:____
Physicians outside this practice:____

What phone number should we call to leave a message to remind you of an appointment or to communicate with you?____

My signature below, gives my consent, for doctors at Soft Tissue Center at Diagnostic and Interventional Spinal Care, to take a medical history, perform a physical examination, derive a diagnosis, order tests if indicated, and/or render treatment as indicated.

______________________________ ____________________
Patient signature Date