Dear Patient: *This information is considered confidential. In order for us to understand your condition properly, please be as thorough, neat, and accurate as possible while completing this form. Thank you.*

QUINCE ORCHARD MEDICAL CENTER
Pain relief lives here

UPDATE OF PATIENT INFORMATION

Name _____ Date _____

Has any of the following changed?		**Please indicate change (if applicable):**
Name	❑ Yes ❑ No	_____
Address	❑ Yes ❑ No	_____
Phone	❑ Yes ❑ No	_____
Email	❑ Yes ❑ No	_____
Insurance	❑ Yes ❑ No	_____
Pharmacy	❑ Yes ❑ No	_____
Primary Care Physician	❑ Yes ❑ No	_____
Employer	❑ Yes ❑ No	_____
Marital Status	❑ Yes ❑ No	_____

Where may we leave a detailed message, including your medical information, if necessary?

❑Home ❑Work ❑Cell

Emergency Contact Name _____

Phone Number _____ Relationship _____

REASON FOR VISIT

Current Complaint _____

When Did Symptoms Start? _____

What Makes You Feel Better? _____

What Makes You Feel Worse? _____

Symptoms are: ❑Improving ❑Getting Worse ❑About the Same

Symptoms are: ❑New ❑Recurring ❑Ongoing ❑Other : _____

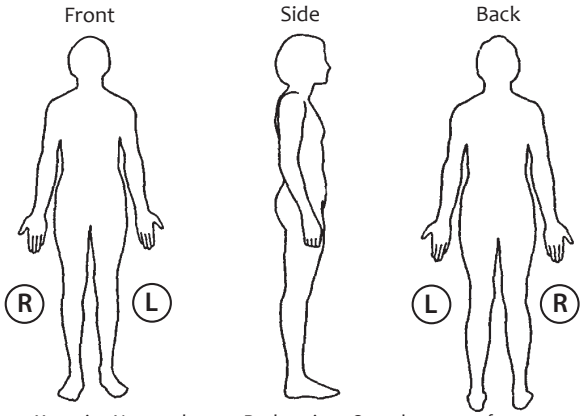
Condition is due to: ❑Traumatic Injury ❑Surgery ❑Overuse ❑Congenital ❑Unknown ❑Other

Is your condition a result of a: ❑Work Injury? ❑Auto Accident?

I have: ❑Loss of bowel and bladder control ❑Pain with coughing/sneezing

Please use illustration to diagram your symptoms:

Describe any other types of symptoms:



X = pain N = numbness B = burning O = other type of symptom

CURRENT MEDICAL HISTORY

Date of Last Physical Examination _____
Any Allergies to Medications? _____
Current Assistive Devices (cane, crutches, etc.)_____
Current Medications (including over-the-counter meds) _____
_____
Radiological Tests Related to Current Medical Complaint: ❑Xray ❑MRI ❑CT Scan ❑EMG ❑NCV ❑Other: ___
_____Location _____
Prior Treatments For Current Condition (surgery, injections, acupuncture, etc.) _____
_____
Since your last visit, have you had any other new medical problems, trauma, or surgical procedures?_____
_____
_____
_____

As needed, may we share information on your medical condition and care with other health care providers?
❑ Yes ❑ No

After reading and filling out this Health Questionnaire, your signature will verify that all information you have given us is accurate in its entirety to the best of your knowledge.

PATIENT'S SIGNATURE _____ **DATE**_____