Dr. Robert Pashman
New Patient History Form

Date:

Referred By: Specialty:

Address: Phone Number:

Patient Name: Home Phone: Cell Phone:

Home Address: City,State, Zip:

email Work Phone: Fax Number:

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced Sex: Date of Birth:

SSN Religious Preference: Ethnic Group:

Patient Employer Name: Occupation:

Employer's Address: Employer's Ph#:

Emergency Contact: Contact Ph# & relation

Complaint:

◯ Worker's Comp Attorney: Phone #:

◯ Auto Injury

◯ Personal Injury Address: DOI:

Primary Insurance: ◯ HMO ◯ PPO ◯ POS Insurance Ph#

Insurance Address: Group#:

ID# Effective Date: Coverage Code: Subscriber Name:

If patient is not the subscriber: DOB SS# ***of the subscriber***

Employer Name: Occupation: Phone:

Employer Address:

Film Status:

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Patient Name:

Secondary Insurance: ◯ HMO ◯ PPO ◯ POS

Insurance Address: Insurance Ph#

Group# ID# Effective Date: Coverage Code:

Workers Compensation (if applies)

Name of Insurance Carrier:

Address of Insurance Carrier:

Name of Adjuster: Adjuster Ph#: Adjuster Fax#:

Claim #: Date of Injury:

Name of Employer at time of injury:

Address of Employer at time of injury

Phone# of Employer at time of injury

Patient History

Name: Date: Age: Occupation:

Referred By:

When did symptoms first appear? Are they symptoms:

Body parts Affected:

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Type of Pain:

Pain Radiation:

Degree of pain you are currently experiencing:

Please describe any other symptoms:

What position and/or medication relieves or pain?

Do you have any pain, numbness, tingling, or weakness in you arms or legs?

Are you presently working:

If you are on disability when did it begin?

Have you had any treatment (including xrays, tests, therapy, ect) or seen any health provider for this injury? Please describe?

Have you tried any home treatments or medications? Please describe:

Please list previous diagnosis and treatments given or recommended?

Please list any test you have had in the past related to your problem (MRI, X-Ray, Etc.)

Test/Study: Test Date: Result:

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Patient Name:

Test/Study: Test Date: Result:

Notes:

Have you recently had any of the following (check all that apply)

☐ Fatigue	☐ Fainting	☐ Memory Loss	☐ Depression	☐ Stress
☐ Heartburn	☐ Difficulty Voiding	☐ Shortness of Breath	☐ Sleep Difficulty	☐ Weakness
☐ Itching	☐ Headaches	☐ Numbness	☐ Tingling	☐ Nervousness
☐ Urinary Incontinence	☐ Nausea	☐ Vomiting	☐ Chest Pains	☐ Ulcers
☐ Early Awakenings	☐ Facial Pain	☐ Hearing Difficulty	☐ Loss of Appetite	☐ Bowel Problems

☐ Loss of Concentration

describe: above symptoms

Are you:

Are you pregnant?

Past medical history: Please check any of the following which you have had:

☐ Respitory problems, asthma, hayfever	☐ Heart Disease	☐ Cancer	☐ Kidney Problems
☐ Gastrointestinal problems, ulcers	☐ Arthritis, Gout	☐ Circulatory/CVA	☐ Urinary Problems
☐ Depression, Psychological	☐ Drug Abuse/Alcohol Abuse	☐ Liver Problems	
☐ Problems with ears, eyes, nose, throat	☐ Diabetes, Hypoglycemia	☐ Hypertension	

Please explain any of the above

Have you had any prior surgeries? Please describe

Have you had any previous spine surgeries? If so, type and date:

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Patient Name:

Are you currentl y seeking treatment for any other medical conditions?

Please list all medications you are taking and the daily dosage:

Are you taking any herbal or vitamen supplements? If so, please list:

Are you allergic to any medications.food, other? If so, please list:

Family Medical History:

Is there a history of Spinal problems in your family? If yes, please explain:

Is there a family history of other medical problems? If so, please describe:

Social History:

Age: Height: Weight Marital Status Children:

Do you smoke? If yes, how much?

Is there any history of drug or alcohol abuse?

Do you drink alcohol? If yes, how much?

Describe usual physical activity: type and frequency:

Primary Care Physician:

Name: Address: Phone:

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New Patient History Formt

Automobile Injury History

Date of accident | Time: | Where did the accident occur?

Describe the accident in your own words:

What was your position in the car? | If passenger, were in sitting in the:

Did you strike the other vehicle? | Was you car struck by the other vehicle?

Was the impact from the | At the time of the impact: were you:

Were both hands on the steering wheel? | Was your foot on the brake? | Were you wearing a seatbelt?

Were you braced for impact? | Where were you in the car after the accident?

Did you strike anything in the vehicle at the time of impact? | If yes:, specify:

Please state part of body: | Were you unconscious? | In a daze?

Did you go to the hospital

How did you get to the hospital? | Name of hospital:

Did the ambulance place you in: ☐ Neck Collar ☐ Splints ☐ Brace

Attending Dr. | Were xrays taken | What was the diagnosis?

Were you admitted to th e hospital? | How long did you stay?

What treatment did you receive?

Describe your syptoms from the day following your accident to todays date.

What recommendations were made? ☐ See own doctor ☐ See specialist ☐ Physical Therapy

Before your injury, were you capable of working on an equal basis with others your age?

Are your work activities restricted due to accident? | Are your home activities restricted as a result of this accident?

If yes, percentage of restriction | Do you have a copy of the police report?

If yes, please bring a copy of the report with you to your doctor's appointment.

Signature Field | Date:

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