THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last First (Legal) MI Nickname

Date of Birth _____ SSN _____

Cell Phone _____ Work Phone _____ Home Phone _____

Mailing Address _____ City _____

State _____ Zip Code _____

Email address _____

Guarantor Name & DOB (if under 18) _____

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Would you like to share your visit notes with your PCP/Referring Provider? Y ☐ N ☐
(If no, skip below)
Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you hear about us?

Family/Friend ☐ Website/Social Media ☐ TV/Print Ad ☐ Past Patient ☐ Other ☐

Medical professional referral ☐ Name: _____

Is this a work-related injury? Y ☐ N ☐

PRIMARY INSURANCE _____ MEMBER ID _____ GROUP ID _____

POLICY HOLDER NAME _____ DOB _____ RELATIONSHIP _____

SECONDARY INSURANCE _____ MEMBER ID _____ GROUP ID _____

POLICY HOLDER NAME _____ DOB _____ RELATIONSHIP _____

THE STEADMAN CLINIC

Patient History Form

Please PRINT and fill out completely

Patient Name_____ Todays Date _____

Date of Birth:_____Age:_____Height:_____Weight:_____

History of Injury

Is this related to a: ☐ Work Injury? ☐ Sport Accident? Or ☐ Motor Vehicle Accident? If So, What State? _____

Which Body Part is Injured? _____ ☐Right / ☐Left Hand Dominance: ☐Right / ☐Left

Please list the Injury/Accident Date:_____ If Chronic list how long: _____

Please describe in your own words: (How the Initial Injury Occurred AND how it Limits Your Activity)

_____

_____

Please Rate Your Pain on a Scale of 1 to 10: (10 being the most painful)

Rest: 0 1 2 3 4 5 6 7 8 9 10 At Its Worst: 0 1 2 3 4 5 6 7 8 9 10

Is the Pain: ☐ Constant or ☐ Occasional Has it Been: ☐Worsening ☐ Stable ☐ Improving

Describe the Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Sensitive to Touch

Do you have Pain at Night? ☐Yes / ☐ No Does the Pain Keep or Wake you from Sleep? ☐ Yes / ☐No

What Symptoms are You Experiencing?

☐Locking ☐Catching ☐Giving Way/Instability ☐ Popping ☐ Grinding ☐ Bruising ☐Numbness ☐Tingling

☐Pain ☐Weakness ☐ Swelling Other (please describe) _____

What, If Anything, Makes Your Symptoms Better?

☐ Rest ☐Activity ☐Cold Therapy ☐ Heat Therapy ☐ Medication ☐ Other (Please describe): _____

What, If Anything, Makes Your Symptoms Worse?

Inactivity ☐ Exercise ☐(describe): _____ Other (Please describe): _____

What Treatment Have You Tried for this Injury?

☐ Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing

☐ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):

☐ Physical Therapy (Date Started): _____ ☐ Acupuncture(Date Started):_____ ☐Other:_____

☐ Medications:_____ ☐ Chiropractic(Date Started): _____

Have You Seen Another Physician for This Injury? Yes ☐ No ☐ Were You Referred? ☐ Yes ☐No

If Yes, Who/Where? _____

Are you Interested in Surgery for this Problem? ☐Yes / ☐ No / ☐ Unsure

Have You Had Any of the Following Tests/Studies?

Test	Date (Month/Year)	Facility? (Clinic/Hospital)
X-Ray		
MRI		
CT Scan		
EMG/NCV		
Discogram		
EKG		
Blood Tests		
Other		

Recreational Activities: _____

Current, regular exercise program (if any): _____