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All Bolded fields on this page are mandatory.

Date: _____

Patient's Legal Name: _____ Name you go by: _____

Date of Birth: ____/____/____ Current Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip code: _____

Primary Phone: _____ type: cell/home/work

Alternate Phone: _____ type: cell/home/work

Email address: _____

Emergency Contact: _____ Phone: _____

Spouse or Parents Name: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: (if different from PCP) _____

Occupation: _____ Employer: _____

Person responsible for payment (if not above) _____

Phone: _____ Address: _____

City, State, Zip: _____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

Name and date of birth of Primary cardholder: _____

Is this a work related Injury? Y N Has your employer been notified? Y N

Date of Injury: _____ Claim # _____ Adjuster: _____

Phone: _____

Is this injury a result of an accident? Y N Date of Accident: _____

Claim # _____ Attorney: _____

Please contact your primary care physician to make sure a referral has been sent to us if your insurance carrier requires one. You are fully responsible for payment in the event we do not receive the appropriate insurance referral authorization prior to your date of service. If you have an HMO plan, you most probably do need a referral from your PCP, which would include an insurance provider recognized referral authorization number, number of visits and expiration.

Mother: _____

Father: _____

MEDICATIONS: (Please include over the counter drugs, supplements, and vitamins):

1. _____

3. _____

2. _____

4. _____

IMMUNIZATION INFO:(Up to Date/Delayed/specify other) _____

BIRTH HISTORY:

Number of weeks: _____ Prenatal Problems: _____

Duration of labor/Pushing: _____/_____ Delivery Type (vaginal or C-section): _____

Procedures/Complications: _____

Condition at Birth: _____

MEDICAL PROBLEMS:

1. _____

3. _____

2. _____

4. _____

SURGICAL HISTORY:

1. _____

3. _____

2. _____

4. _____

IMAGING STUDIES: (X-rays, CT scans, MRI's etc.)

1. _____

3. _____

2. _____

4. _____

TRAUMA HISTORY: (please give details and approximate dates)

Head trauma: _____

Motor Vehicle Accidents: _____

Injuries: _____

Dental Work: _____

Emotional traumas: _____

Other: _____

HOME ENVIRONMENT:

Who does your child live with? _____

Environmental exposures (wood smoke, pets, mold, etc.): _____

Quality of home life? _____

DEVELOPMENTAL HISTORY:

Age appropriate milestones (motor skills, language, etc.)? If not, please explain: _____

Academic/Athletic Performance: _____

Social Skills (with peers, adults, friends): _____

HEALTH MAINTENANCE:

Physical Activity (type/frequency): _____

Hobbies (type/frequency): _____

Nutrition (tell us about your child's dietary intake): _____

Fluid Intake: _____

Sleep/Rest (hours per day/quality): _____

FAMILY HISTORY:

Ethnicity: Hispanic Non-Hispanic Race: _____

	Age	Health Problems	Age at Death/Cause
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sisters:	_____	_____	_____
Brothers:	_____	_____	_____

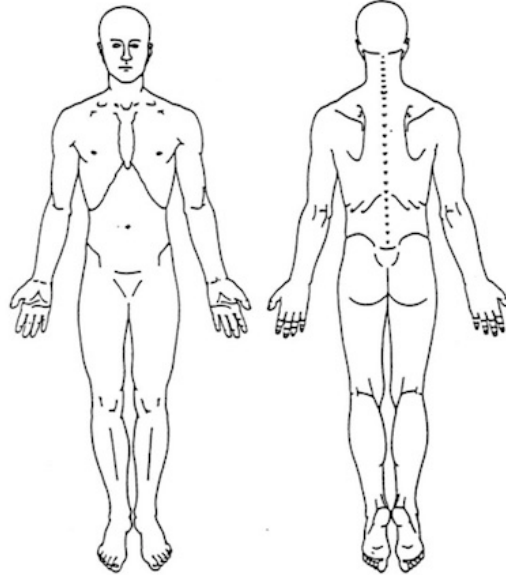
CIRCLE IF PRESENT IN ANY BLOOD RELATIVES (Include parents, grandparents, brothers, sisters, children, cousins, aunts and uncles):

- Diabetes Heart Disease High Blood Pressure Lung Disease Tuberculosis Epilepsy
- Migraines Arthritis Kidney Disease Depression Glaucoma Suicide
- Obesity Blood DiseaseChronic Muscle Pain Thyroid Disease Degenerative Discs
- Cancer (type) _____
- Other _____

LOCATION OF PAIN:

Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your child's symptoms.

- “N”=Numbness
- “S”=Stabbing
- “B”=Burning
- “P”=Pins and needles
- “A”=Aching Pain



How did your child's current episode begin? Suddenly Gradually

Describe the onset of the pain:

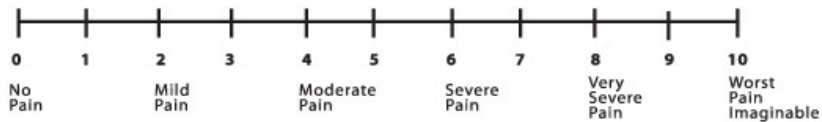
How long ago did the current episode begin? _____

Has the pain lessened, stayed the same, or worsened? _____

What does the pain feel like? (circle all that apply):

- | | | | | |
|-------------------|-----------|-----------|--------------|-------------|
| Throbbing | Splitting | Shooting | Stabbing | Hot/Burning |
| Tiring/Exhausting | Aching | Sickening | Sharp | Heavy |
| Tender | Gnawing | Cramping | Other: _____ | |

How bad is the pain **today**, on a scale of 0-10 with 0 being no pain, and 10 being the worst pain imaginable.



Which number (0-10) describes the pain at its worst? _____

Have you consulted any other healthcare practitioner for pain relief of your current problem? If so, please list:

Please mark all the following treatments that has been used for pain relief:

	Helped Pain	worsened pain	no change
massage therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hot packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brace support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
injection therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mark the effect of each of the following on your child's pain:

	Increases	Decreases	No change
sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coughing/sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE MARK ALL THAT APPLY:

GENERAL

- Weight Gain or Loss
- Change in Appetite/Thirst
- Fatigue
- Weakness
- Change in Sleep Patterns
- Fever
- Chills
- Night Sweats
- Cold Intolerance
- Change in Hair/Skin
- Easy Bruising
- Irritability/Indifference

HEAD/ EYES/ EARS/ NOSE/

THROAT

- Eye Pain/Disease
- Visual Problems/ Wears Glasses
- Ear Pain/ Frequent Ear Infections
- Ringing in Ears
- Hearing Problems
- Chronic Sinusitis
- Nasal Discharge
- Difficulty Swallowing
- Sore Throat
- Swollen Glands

SKIN

- Itching
- Psoriasis/Eczema
- Lumps
- Change in Moles/ Warts/ Lesions
- History of Cancer
- Other Rash

MUSCULOSKELETAL DISEASE

- Joint Pain
- Redness
- Swelling
- Stiffness
- Frequent/Severe Muscle Pain
- Weakness

- Disc Herniation
- Abnormal Spinal Curve
- Workers Comp Injuries

GASTROINTESTINAL

- Nausea/Vomiting
- Abdominal Pain
- Ulcer
- Heartburn
- Reflux
- Hiatal Hernia
- Change in Bowel Habits
- Irritable Bowel Syndrome
- Excessive Gas
- Food Intolerance
- Crohns
- Ulcerative Colitis
- Liver/Gall Bladder

RESPIRATORY

- Wheeze
- Asthma
- Use of Inhalers
- Shortness of Breath
- Frequent Cough
- Bronchitis
- COPD
- Pneumonia
- Flu
- Respiratory Syncytial Virus

URINARY

- STD'S
- Frequent UTI
- Pain with Urinating
- Incontinence
- Kidney Stones

NERVOUS SYSTEM

- Seizures
- Tremors
- Headaches
- Head Injury
- Numbness/Tingling
- Loss of Coordination
- Dizziness/Vertigo

- Poor Memory
- Fainting
- Change in Taste or Smell
- Neurological Disease

BLOOD/LYMPH

- Anemia
- Bleeding
- Jaundice

PSYCHOLOGICAL/ENDOCRINE

- Often Nervous/Worries
- PTSD
- Constant Feelings of Sadness/Hopelessness
- Hospitalized for Mental Illness
- Psychological Diagnosis
- Decreased Sense of Well-Being/Energy
- Decreased Mental Sharpness/Forgetful
- History of Thyroid Disease

FEMALE

ENDOCRINE/REPRODUCTIVE

- Pain with Intercourse
- Menstrual Irregularity/Flow
- Bloating
- PMS
- Breast Lumps/Irregularity

CARDIOVASCULAR

- Angina
- Palpitations
- Arrhythmia
- Heart Murmurs
- Blood Vessel Disease
- Clots
- Thrombophlebitis
- Foot/Ankle Swelling
- Heart Attack
- Heart Failure
- Chest Pain
- HBP

MARK ALL THAT APPLY:

- No known FOOD allergies
- No known DRUG allergies
- No known ENVIRONMENTAL allergies

IF YOU HAVE AN ALLERGY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

1. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficulty Speaking/Swallowing
- Loss of Consciousness
- Fast/Slow/Irregular Heartbeat
- Chest Pain

2. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficulty Speaking/Swallowing
- Loss of Consciousness
- Fast/Slow/Irregular Heartbeat
- Chest Pain

3. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficult Speech/Swallowing
- Loss of Consciousness
- Irregular Heartbeat
- Chest Pain

- **NOTICE OF ACKNOWLEDGEMENT:** I acknowledge that I have received the notice of privacy practices posted in the office. I understand that a copy of our privacy practices is available to me upon request.

- Signature: _____ Date: _____

- Print Name: _____ DOB: _____

- **AUTHORIZATION OF PAYMENT:** I authorize payment of my medical benefits to Jennifer Lakis, D.O. for services rendered. I understand that I am financially responsible in the event that payment is denied or rejected by the insurance company and for those charges not covered by policy benefits, as well as deductibles and co-insurance that are not covered by this assignment.

- Signature: _____ Date: _____

- **RELEASE OF NECESSARY MEDICAL INFORMATION:** During the course of my treatment I understand that certain tests, such as an MRI, CT Scan, or consultations with other physicians may be necessary. I authorize the release of any medical information for these purposes. I authorize the release of any medical information for these purposes. I authorize the release of any medical information necessary to process my disability and/or medical claim.

- Signature: _____ Date: _____

- **LATE CANCEL AND NO-SHOW POLICY:** All patients are granted one late cancel without additional charge per calendar year. There is a \$25 charge for any appointment cancelled less than 24 hours of the scheduled time. There is a \$100 charge for any no-show to an appointment. I understand that arriving more than fifteen minutes late for any scheduled appointment will be considered a no-show and treatment is not guaranteed.

- Signature: _____ Date: _____

FOR OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORTS: the patient presented for treatment on this date and was provided with a copy of the notice of privacy practices. A good faith effort was made to obtain a written acknowledgement or receipt of the notice. However, an acknowledgement was not obtained for the following reason: _____ Patient name: _____

Signature of physician or employee: _____ Date: _____