GRAND OAK
HEALTHCARE
SPINAL CARE - OCCUPATIONAL MEDICINE

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www.MyGrandOak.com

Name: _____ Birthdate: ___/__/_____ Sex: Male_____Female_____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell #: _____Cell Provider: _____Work#: _____

Email: _____ Preferred Language: _____

Preferred method of communication for office appointments: Text_____ Email _____

Marital Status: Married ____ Divorced ____ Single ____

Occupation: _____ Employer: _____Yrs Employed: _____

Employer Address: _____City: _____State:_____Zip:_____

Spouse's Name: _____Occupation: _____Employer: _____

Emergency Contact and Phone Number: _____

Insurance Provider: _____ Subscriber/Member #: _____

What is your chief complaint: _____

Cause of condition: _____

Primary Care Physician (PCP): _____

Have you had similar conditions in the past? _____ Have you had any prior documentation?_____

How did you hear about us? _____

I clearly understand that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Patient Signature: _____ **Date:**_____

Health History Form

Name _____

Age _____ Date of birth _____ Sex _____

Occupation _____

Patient's Chief Complaint

Medications (List all medications you are currently taking.)		Allergies (List all allergies)

Patient's Past History:
Do you have or have you ever had the following? Check each box that is answered "yes".

- Headaches, dizziness, fainting
- Blurred vision
- Sinus trouble
- Asthma
- Sore throats
- Shortness of breath
- Persistent cough
- Night sweats
- Arthritis
- Chest pain
- High blood pressure
- Heartburn or indigestion
- Nausea and/or vomiting
- Stroke
- Ringing in Ears
- Sudden weight gain or loss
- Kidney disease or stones
- Painful and/or difficult nutrition
- Become tired or upset easily
- Depression
- Convulsions
- Back pain or injury
- Diabetes
- Prior spinal surgeries

Please use the space below to explain any "yes" answers.

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family and Social History:

	Yes	No	Amount/How Often:
Do you use tobacco?	○	○	_____
Do you use drugs?	○	○	_____
Do you use alcohol?	○	○	_____
Do you exercise regularly?	○	○	_____

Relation	**Age**	**State of Health**	**Serious Illness and/or Cause of Death**
Father			
Mother			
Brother			
Sister			

Patient Signature: _____ **Date:** _____