CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:_____ Date of Birth_____

Name: _____

Address_____ City_____ State_____Zip_____

Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age _____

Male Female email address _____

Marital Status: Married Single Divorced Separated Other

_____

Mother's Name if minor_____Father's Name if minor_____

Name of Individual to contact in case of emergency: _____Phone : _____

Number of Children: ____ Names and ages of children: _____

Your Occupation: _____ Your Employer _____

Employer's Address_____Employer's Number _(____)_____

Who is your Primary Care Physician? _____

Referred to this office by: TV Healthbeat Mailing Star News Location Internet

Google Natural Awakening Health & Medical Magazine Dr. Graf's Book

Friend – Name? _____ MD – Name? _____

Other_____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY

1. _____ Date _____
2. _____ Date_____
3. _____ Date_____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

Do you have a Pacemaker? Yes No Do you have a Defibrillator? Yes No

What type of care are you looking for? Temporary Relief Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. _____
2. _____
3. _____
4. _____

THIS PROBLEM IS: RAPIDLY IMPROVING SLOWLY IMPROVING GRADUALLY WORSENING

FLUCTUATES BUT GETTING BETTER REMAINS THE SAME RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE Morning Afternoon Evening All the time

APPROXIMATELY WHEN DID YOU START HAVING SHOULDER PROBLEMS? _____

_____

SYMPTOMS DEVELOPED FROM: Job injury Sports Injury Normal Wear & Tear Other

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Which Shoulder do you experience pain/stiffness in? ☐Right ☐Left ☐Both
2. Do you experience Shoulder Pain/Stiffness at rest? ☐No ☐Yes
3. Have you had x-ray/MRI on your Shoulder? ☐No ☐Yes ☐Unsure
4. Has your Shoulder problem interfered with activities in the last six months? ☐No ☐Yes, please explain: _____
5. Are you able to place your hand on top of your head? ☐No ☐Yes
6. Are you able to place your hand behind your back? ☐No ☐Yes
7. Have you tried taking medication for your Shoulder problem? ☐No ☐Yes _____
8. Have you tried physical therapy for your Shoulder problem? ☐No ☐Yes
9. Have you tried using a Shoulder Sling? ☐No ☐Yes
10. Have you tried Manipulation Under Anesthesia on the affected Shoulder? ☐No ☐Yes
11. Have you had surgery on the affected Shoulder? ☐No ☐Yes _____
12. Have you tried an injection into the affected Shoulder? ☐No ☐Yes _____

PLEASE CICLE YOUR LEVEL OF SHOULDER DISCOMFORT ON THE SCALE BELOW.

NO DISCOMFORT 1 2 3 4 5 6 7 8 9 10 WORST DISCOMFORT

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Doctors Jason Graf, Aaron Richardet, Nikki Bailey and appointed staff to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature**(STAFF)** _____ Date _____