**Lone Star Spine and Rehab**
**Confidential Patient Case History**
**13777 Judson Road #107**
**San Antonio, TX, 78233**
This confidential history will be part of your permanent records.

**Today's Date**: ____ / ____ /_____

**Patient Title**: □Mr. □Mrs. □Ms. □Dr. □Other_____
**First Name**: _____ **Middle:**_____ **Last**:_____
**Address:** _____ **City**_____
**State**_____ **Zip code**_____ **SSN:** _____-_____-_____
**Gender:** □Male □Female **Marital Status:** □Single □Married **Language:** □English □Spanish □Other_____
**Race:** □White □Black/African American □Hispanic □Other_____
**Date of Birth**: _____ /_____ /_____ **Age:** ____ **Home Phone:** _____ **Cell Phone:** _____
**Are we able to leave a detailed message on your phone lines?** _____
**Work Phone:** _____ **Email Address:** _____
**Emergency Contact Name:** _____ **Relationship:**_____ **Phone Number:** _____
**Employment Status:** □Employed □Student □Retired □Other_____ □N/A
**Occupation:** _____ **Describe Job Duties(sitting, standing, lifting ect.):** _____
_____

**Family History:**

Father Illnesses/Diseases _____

Mother Illnesses/Diseases _____

**Current Medications**: If none check here□ 1)_____ 2)_____
3)_____ 4)_____5)_____6)_____

**Allergies:** If none check here□ 1)_____2)_____3)_____

**List Surgical Operations:** _____

**Please list any other medical conditions not already covered:**

_____
_____

**Female Patients ONLY: Date of last menstrual cycle** _____

**PLEASE CIRCLE ONE: Are you currently pregnant? YES __ weeks NO UNSURE**

**Medical History:**

| | | | | | |
|---|---|---|---|---|---|
| □ Muscle Pain | Now□ | Past□ Never□ | □ Seizures | Now□ | Past□ Never□ |
| □ Muscle Weakness | Now□ | Past□ Never□ | □ Joint Pain | Now□ | Past□ Never□ |
| □ Muscle Cramps | Now□ | Past□ Never□ | □ Joint Stiffness | Now□ | Past□ Never□ |
| □ Muscle Twitching | Now□ | Past□ Never□ | □ Cancer | Now□ | Past□ Never□ |
| □ Vertigo/Dizziness | Now□ | Past□ Never□ | □ Kidney Stones | Now□ | Past□ Never□ |
| □ Hand Trembling | Now□ | Past□ Never□ | □ Loss of Sensation | Now□ | Past□ Never□ |
| □ Poor Coordination | Now□ | Past□ Never□ | □ Bowel Trouble | Now□ | Past□ Never□ |
| □ Weak Hand Grip | Now□ | Past□ Never□ | □ Bladder Trouble | Now□ | Past□ Never□ |
| □ Mental Illness | Now□ | Past□ Never□ | □ Diabetes | Now□ | Past□ Never□ |
| □ High Blood Pressure | Now□ | Past□ Never□ | □ Sexual Problems | Now□ | Past□ Never□ |
| □ Angina/ Chest Pain | Now□ | Past□ Never□ | □ Arthritis | Now□ | Past□ Never□ |

□ Heart Disease Now□ Past□ Never□ □ Depression/Anxiety Now□ Past□ Never□
□ Stroke Now□ Past□ Never□

**Social History:**

Caffeine Use □Heavy □Moderate □Light □N/A Work/Job □Heavy □Moderate □Light □N/A

Exercise □Heavy □Moderate □Light □N/A Mental Work □Heavy □Moderate □Light □N/A

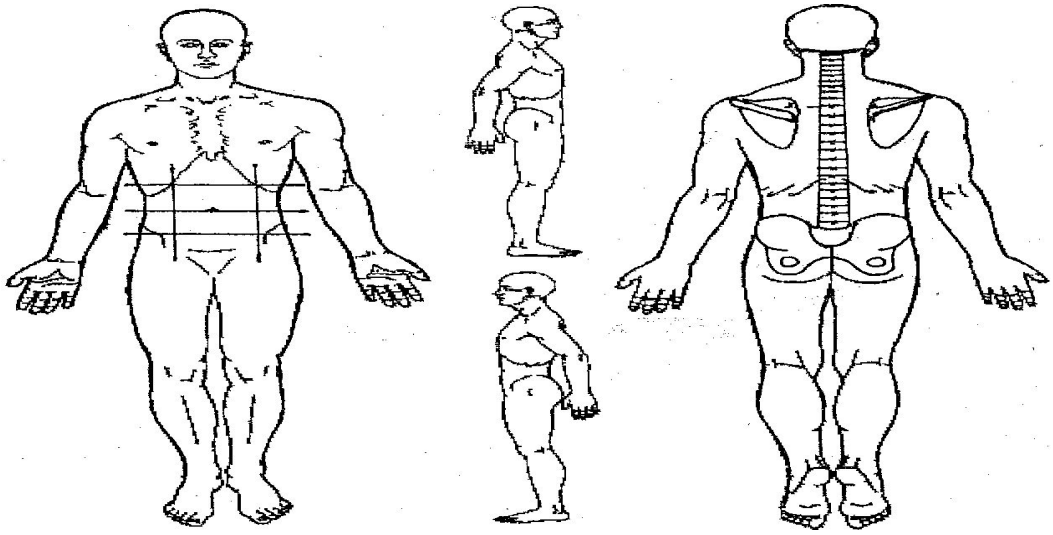
Alcohol Use □Heavy □Moderate □Light □N/A Tobacco Use □Heavy □Moderate □Light □N/A

**Other doctors/therapists who have treated this condition**:_____
_____

**Is this condition:** □Getting Better □Unchanged □Getting Worse
**Is this condition interfering with your:** □Work □Sleep □Daily Routine □Other: _____
**Does anything make it feel worse?** _____
**Does anything make this feel better?** _____

**Symptoms:** Mark the areas of your symptoms on the picture below.

Use the following symbols:
**P**ain- **P** **A**ches- **A** **N**umbness- **N** **S**tabbing- **S**
Pins/Needles- **X** Muscle **T**ightness/Spasm- **T** Shooting Pain- □



Circle how severe your symptoms are now/today? (With 0 being no pain and 10 being the worst pain)
None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

Circle what the most severe your symptoms have been before today? (With 0 being no pain and 10 being the worst pain)
None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

I certify that the above information is correct.

**Patient or Guardian's Signature**_____ **Date**_____

**Personal Injury Questionnaire**

Today's Date: __ / __ /____

First Name: _____ Middle: _____ Last: _____

Describe the accident in your own words:

_____

_____

_____

Date of accident? ___ /___ / ___

Where did the accident occur? Street/Intersection: _____City: _____ State: _____

Where you the □Driver □Passenger: □Front Seat □Rt Rear Seat □Lt Rear Seat?

What type of vehicle were you in? _____

How much is the vehicle damaged? _____ □total damage

What type was the other vehicle? _____

What speed were you driving? _____ What speed was the other vehicle's speed? _____

Was the impact from the □Front □Rear □Lt side □Rt side?

In what direction were you pushed? □Forward □Backward □Sideways

Were you wearing your seatbelt? □Yes □No

Did you brace your feet while hitting the breaks? □Yes □No

Did you brace your arms on the steering wheel? □Yes □No

Did the airbags deploy? □Yes □No

Were you examined at the scene of the accident by an EMT? □Yes □No

Did you go to the hospital? □No □Yes, Name of Hospital_____

Please list any and all symptoms you had immediately after the accident:

_____

_____

_____

Please list your current symptoms:

_____

_____

Patient Signature: _____ Date: _____

**LONE STAR SPINE AND REHAB**
**PERSONAL INJURY INSURANCE INFORMATION**

Date of Accident:_____ Please circle one: Driver or Passenger
Description of your vehicle: (Year, Make, Model)_____
Police Notified? Yes or No Police Report Obtained: Yes or No

**Insurance Information for at Fault:**
Name of Insured:_____Policy#:_____
Claim #:_____
Adjuster Name:_____Adjuster Phone:_____

**Personal Auto Insurance:**
Name of Insured:_____Policy#:_____
Claim #:_____
Adjuster Name:_____Adjuster Phone:_____

**If you were a passenger, please provide the insurance information of person driving:**
Name of Driver:_____Phone:_____
Name of Insured:_____Policy#:_____
Claim #:_____
Adjuster Name:_____Adjuster Phone:_____

**Health Insurance:**
Name of Insurance:_____Phone:_____
Insured's Name:_____Insured DOB:_____
Policy Number:_____Group Number:_____

**Attorney Information:**
Attorney Name:_____
Address:_____
Phone:_____Contact Person:_____

**ANY CHANGES TO LEGAL REPRESENTATION OR INSURANCE COVERAGE WILL NEED TO BE REPORTED TO OUR OFFICE IMMEDIATELY.**

*Lone Star Spine and Rehab*
*13777 Judson Rd #107*
*San Antonio, TX, 78233*
*Tel (210)650-0940 Fax (210)650-0943*
*LONESTARSPINEANDREHAB@GMAIL.COM*

I, _____ authorize _____ to release all medical records to Lone Star Spine and Rehab for the purposes of treatment.

DOB:_____

SS #:_____

Signature: _____

Please send all records via fax to (210)650-0943.