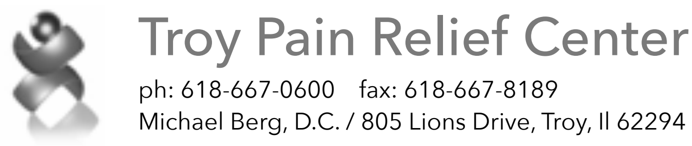

Troy Pain Relief Center

ph: 618-667-0600 fax: 618-667-8189
Michael Berg, D.C. / 805 Lions Drive, Troy, Il 62294

Patient Information

Date: ____________________
First Name _______________________ Last Name ________________________ Middle Initial _______
Address ____
City ____________________________ State ______ Zip Code ______________
Phone (______) _______-________ Email (for special offers) ___________________________________
Date of Birth _____/_____/________ Sex: M ___ F___ Marital Status: Single___ Married ___ Sep ___
Social Security Number: _______-______-_______ Daily activity/work: ___________________________
Employment Status: Employed___ Unemployed___ Homemaker___ Student___

How did you hear about Troy Pain Relief Center

Internet ___ Mail___ Sign___ Insurance___ Friend/Family _______________ Other_________________

History of present complaint

Present Complaint(s): ____
____
____
This condition is due to: Auto accident ____ Injury____ Unknown ____
Other ____
Symptoms appeared: Gradual ____ Suddenly _____
Have you had same symptoms earlier? No ___ Yes (date) ________________
Are the symptoms getting: better ___ same ____ worse ____

Type of pain you are experiencing

sharp___ aching___ throbbing___ dull___
numbness___ tingling___ cramping___
shooting___ other ________________________

Circle location of the pain on the diagram:

Please check below, the percentage of time that you have this pain or discomfort, during your awake time of the day:

___0-25% ___26-50% ___51-75% ___76-100%

Please circle below, on a scale of 0-10 (0 meaning no pain and 10 meaning severe pain), what level are you feeling:

1 2 3 4 5 6 7 8 9 10

What makes your pain feel better? ____
What makes your pain feel worse? ____

What activities do you find it difficult to perform? sitting___ bending___ standing___ walking___ lying down___ other _______________________________

Have you missed work/school due to the symptoms? No _____ Yes _____

What type of treatment have you already received for this particular condition?
medication___ chiropractic___ physical therapy____ other _________________________

Health history (please indicate any related history: past or present)

____
____
____

Pacemaker? yes__ no__ (women) Are you pregnant? yes__ no__

Daily Activities

Work requirements: sitting/computer___ standing___ a lot of walking___ heavy labor___

Daily exercise: none___ mild___ moderate___ heavy___

Any limitations with job activities or hobbies due to your pain?_________________________
____

Our office will provide insurance billing services for you if you so desire, as a courtesy. Remember that you are ultimately responsible for any charges incurred at this office. It is your responsibility to pay any deductibles or co-pays required by your insurance carrier. Your signature on this document indicates that you understand and agree to pay for any outstanding bills occurred in this office.

_________________________________ _____________
Patient Signature Date

_________________________________ _____________
Signature of parent or legal guardian Date