

Symptoms

Reason for visit _____ When did you first notice the symptoms _____

IS this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are you able to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting
___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and goes?

What treatment have you already received for your condition? Medication Surgery Physical Therapy Other

Name and address of other doctor(s) who have treated you for your condition: _____

Health History

Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | | | _____ |

Dates of last exams: _____

(Woman) Are you pregnant? ___ Yes ___ No Nursing? ___ Yes ___ No Taking birth control pills? ___ Yes ___ No

List any types of surgeries which you have had and the dates they occurred:

Please List all medications you are currently taking:

Allergies: _____

What Kind Of Vitamins do you take? _____

What Kind of other supplements do you take (if any)? _____

Do You Smoke? ___ Yes ___ No How much per day? _____

How Much Liquor do you consume on a weekly basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____

And assign directly to Dr. Lawhorn all Insurance benefits, if any otherwise payable to me for the services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Date