



Superior Physical Health, LLC

29 Legion Street • P.O. Box 1091 • Ringgold, GA 30736 • (706) 965-5777 • Fax (706) 965-5787

PERSONAL HISTORY

DATE: _____ CHART NO. _____
Last Name: _____ First: _____ MI: _____ SSN: _____ - _____ - _____
Street Name: _____ E-mail: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Bus. Phone: (____) _____ Cell: (____) _____
Emergency Contact Name: _____ Emergency Contact Phone: (____) _____
Birthday: ____/____/____ Age: _____ Sex: _____ Height: _____ Weight: _____
Driver License: _____ State: _____ Circle One: Married Single Widowed Divorced Separated MINOR
Check One: FULL TIME PART-TIME RETIRED NOT EMPLOYED FULL TIME STUDENT PART TIME STUDENT
Employer/School Name: _____ Occupation: _____
Employer Phone: (____) _____ Employer Address: _____
Name of Spouse/Parent (if a minor): _____ Spouse/Parent Date of Birth: ____/____/____
Spouse/Parent Employer: _____ Spouse/Parent SSN: ____-____-____
Spouse/Parent Employer Address: _____ S/P Employer Phone: (____) _____
Is Today's Visit Related to: Automobile Accident Workers Compensation Other Physical Injury
Date of Injury: ____/____/____ Nature of Injury: _____
Have you been to see any other doctor for today's condition? Yes No
Doctor's Name: _____ Date of Visit: _____
What kind of treatment did you receive? _____
Referred to this office by: _____ Relationship: _____

FEMALE PATIENTS ONLY: Are you pregnant? Yes No Expected Date of Delivery: ____/____/____
Today's Date: ____/____/____ Signature: _____

PAYMENT INFORMATION - Who is Responsible for your bill?

Self
 Primary Medical Insurance: _____ ID No: _____
Policyholder: _____ Policyholder's Date of Birth: ____/____/____
 Secondary Medical Insurance: _____ ID No: _____
Policyholder: _____ Policyholder's Date of Birth: ____/____/____
 Automobile Accident - Contact: _____ Claim No: _____
Insurance / Attorney Name: _____ Phone No: (____) _____
 Workers COMP - Contact: _____ Claim No: _____
Insurance Name: _____ Phone No: (____) _____
 Other (Please Explain): _____

What is your MAJOR COMPLAINT? _____

How long have you suffered with this problem? _____

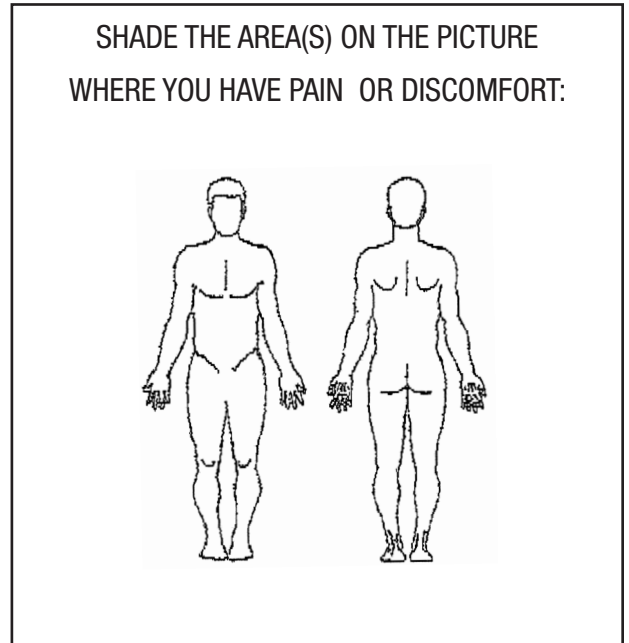
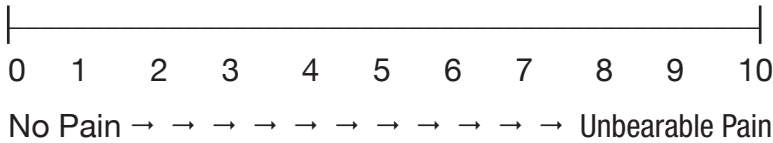
How often does this problem currently bother you? _____

- My Pain is:
- Sharp Dull
 - Stabbing Throbbing
 - Aching Shooting

Along with my MAJOR COMPLAINT, I also periodically have:

- Headache Mid-Back Pain
- Neck Pain Low Back Pain
- Pain, Numbness or Tingling in my Arms or Legs

Rate Your Pain Level for Today - Circle a Number:



- Have you had: Spinal X-Rays? Date: _____ Areas Taken: _____
- MRI? Date: _____ Areas Taken: _____
- CT Scan? Date: _____ Areas Taken: _____

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

FAMILY	PAST	PRESENT	CONDITION	FAMILY	PAST	PRESENT	CONDITION
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Infection, Recent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dizziness / Fainting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Numbness in Groin / Buttocks
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HIV / AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Aneurysm
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cancer / Tumor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pacemaker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Osteoporosis
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy / Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Trauma
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blood Pressure Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Visual Disturbances
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Inability to Control Bladder/Bowels	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prostate Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Psychiatric/Psychologic Condition
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Corticosteroid Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke (Date: _____)

Allergies: _____

Surgeries: _____

Medication(s): _____

I certify that the information on this form is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

PATIENT SIGNATURE: _____ DATE: _____