

Welcome To Our Office (Please fill out completely)

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Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Employer \_\_\_\_\_ Business phone \_\_\_\_\_

Do you rent or own? \_\_\_\_\_ If rent, landlords name \_\_\_\_\_ Phone \_\_\_\_\_

| Insurance NO.1  |  | Insurance NO.2  |  |
|-----------------|--|-----------------|--|
| Name of Co.     |  | Name of Co.     |  |
| Phone           |  | Phone           |  |
| ID#/ Group#     |  | ID#/ Group#     |  |
| Name of Insured |  | Name of Insured |  |
| Insured SS#     |  | Insured SS#     |  |

Other Insurance \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Last visit \_\_\_\_\_

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY \_\_\_\_\_ Phone \_\_\_\_\_

NEAREST REALITIVE NOT LIVING WITH YOU \_\_\_\_\_ Phone \_\_\_\_\_

WHO MAY WE THINK FOR REFERRING YOU \_\_\_\_\_

What is your complaint \_\_\_\_\_

How long have you had it? \_\_\_\_\_ What first caused the problem? \_\_\_\_\_

Is your problem  Getting worse  Better  Not changing How often do you have the problem? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_ What makes your problem better? \_\_\_\_\_

Have you seen anyone else for this problem? Y/N If yes who? \_\_\_\_\_

What treatment was done? \_\_\_\_\_

Do you smoke? Y/N # of packs/ day \_\_\_\_\_ Frequency of alcohol use  Never  Rare  Social  Moderate  Heavy

Physical activity at work:  sitting more than 50% of day  light manual labor  Heavy manual labor  repeated motion \_\_\_\_\_

Has your work been affected by your problem? Y/N How? \_\_\_\_\_

Please list any past illnesses (HIV/ AIDS), Cancer, Heart/ lung, blood disorders, surgeries, etc.) \_\_\_\_\_

Please list any medications, or supplements you are currently taking \_\_\_\_\_

General physical activity  None  Moderate  Strenuous Please Explain \_\_\_\_\_

Is your problem affected by your daily activities or physical activities? Y/N How? \_\_\_\_\_

Any additional comments you feel I should know regarding your condition or past medical history? Y/N \_\_\_\_\_

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize my insurance benefits to be paid directly to the doctor. I am financially responsible non-covered services. I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition. I have read, understood, and agree to the above.

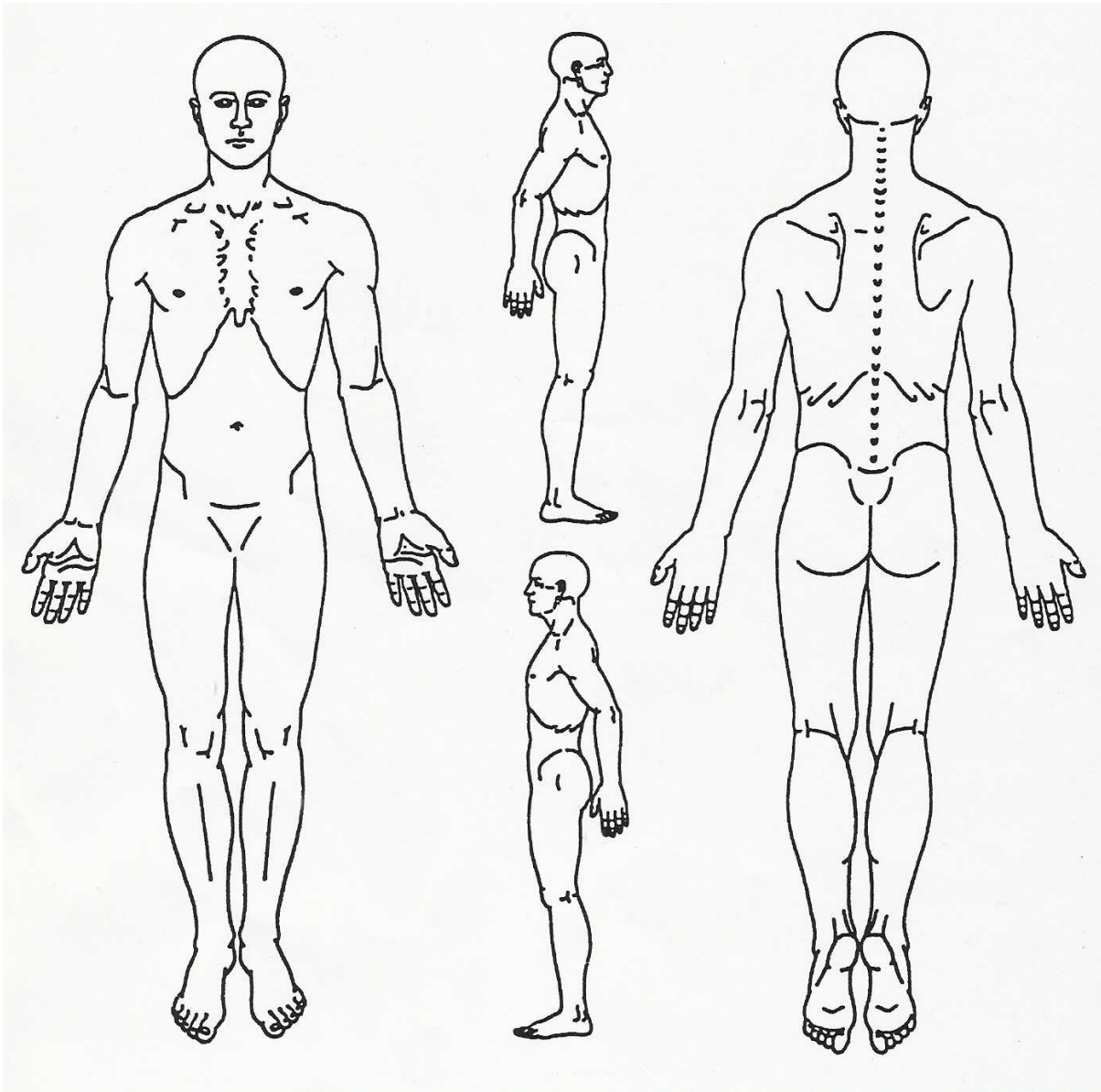
Signature \_\_\_\_\_ Date \_\_\_\_\_



# PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

|                     |                     |                               |                      |
|---------------------|---------------------|-------------------------------|----------------------|
| <b>A = Ache</b>     | <b>B = Burning</b>  | <b>R = Radiating Pain</b>     | <b>D = Dull Pain</b> |
| <b>N = Numbness</b> | <b>S = Stabbing</b> | <b>P = Pins &amp; Needles</b> | <b>O = Other</b>     |



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 ((HIGH)

NAME: (please print) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Banas Sports Therapy PLLC

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