LONGMONT SPINE AND PHYSICAL MEDICINE

FRONTRANGE REGENERATIVE MEDICINE

Appointment Date: _____

Appointment Time: _____

Complimentary Consultation-Intake

Name: _____
Last First MI

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female

Mailing Address _____ City_____ State_____ Zip_____

Phone (H) _____ (W) _____ (Cell) _____

Email _____ How did you hear about us?_____

Do you have an insurance plan that might cover treatment in our office? ❑ YES ❑ NO
*if yes, please give your card to the front desk. We will be happy to call and check your benefits!

Please tell us what brings you to our office:

_____

_____

Office Use Only

Condition: _____ **How Long:** _____

Mode of Onset: _____ **Most recent episode:** _____

What makes it worse: _____

What makes it better: ❑ Ice ❑ Heat ❑ Stretch ❑ Movement ❑ Medication ❑ Other _____

Quality of Sensation: ❑ Dull ❑ Ache ❑ Deep ❑ Superficial ❑ Sharp ❑ Shooting ❑ Numbness ❑ Tingling ❑ Other

Radiation: ❑ Yes _____ ❑ No **Severity/VAS**: Right Now_____ At Worst _____ At Best _____

Timing: During waking hours, do you feel it: ❑ 0%-25% ❑ 26%-50% ❑ 51%-75% ❑ 76%-100%

History of Trauma? _____

How does this affect you at work? _____

How does this affect you at home? _____

How does this affect you during outdoor activities? _____

Verify For: MD Eval Knee XR FSP XR Old School **Other:** _____

Eval Scheduled For: _____ **Benefits Verified:** _____ **Patient notified:** _____