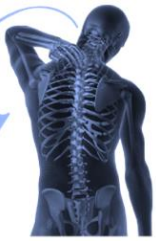
Alaska
Spine and Pain Center
DR. CALEB J. CRAIG



PATIENT INFORMATION

Patient Name: (last, first, middle initial):_____ Date: _____

Date of Birth:_____ SSN:_____ Gender: _____M/_____F

Mailing Address:_____

City/State/Zip:_____

Alternate Address:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address:_____

Who may we thank for referring you?_____ Employer:_____

Employed: _____Full Time _____Part Time ____Unemployed _____Student Occupation:_____

Marital Status: (Please circle one) Single Married Divorced Widowed Separated

Emergency Contact: _____ Relation: _____ Emergency Phone: _____

Parent, Spouse or Responsible Party (If different from patient):

Patient Name: (last, first, middle initial):_____ Date: _____

Date of Birth:_____ SSN:_____ Gender: _____M/_____F

Mailing Address:_____

City/State/Zip:_____

Alternate Address:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address:_____

INSURANCE INFORMATION

Insurance Coverage- PRIMARY

Insurance Company Name:_____

Name of Policy Holder (Insured):_____ Date of Birth:_____

Relationship to Insured: Self Spouse Child Other:_____

Employer:_____ Employer Address:_____

Insurance Coverage- SECONDARY

Insurance Company Name:_____

Name of Policy Holder (Insured):_____ Date of Birth:_____

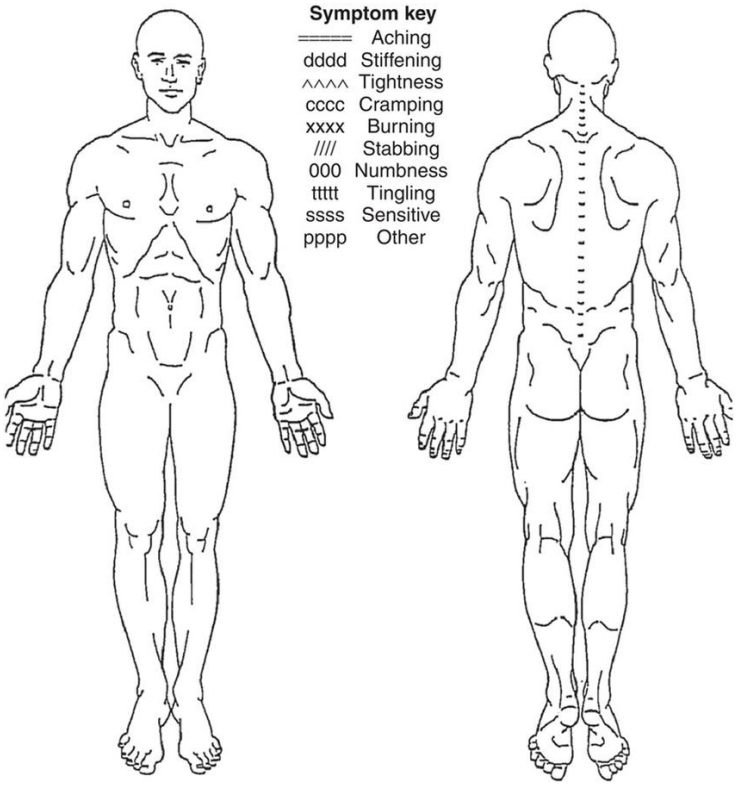
Relationship to Insured: Self Spouse Child Other:_____

Employer:_____ Employer Address:_____

Patient Name:_____ Date:_____ DOB:_____

Patient Symptoms:

Please circle the area of pain and use the key for appropriate descriptors:



Reason for this visit:

Please describe the reason for this visit:

_____

_____

_____

When did this concern begin? _____

Does this concern interfere with: (please circle all that apply) Work/Sleep/Daily Routine/Sex Life/Other: _____

Has this concern occurred before? Yes_____ No_____

Have you ever received Chiropractic care for this concern? Yes_____ No_____ Provider's Name: _____

Date(s) of care: _____

Results: Good_____ Bad_____ Indifferent_____

Have you ever received Massage care for this concern? Yes_____ No_____ Place of care: _____

Date(s) of care: _____

Results: Good_____ Bad_____ Indifferent_____

Have you ever received Medical Care for this concern? Yes_____ No_____ Provider's Name: _____

Date(s) of care: _____

Types of treatments received: _____

Results: Good_____ Bad_____ Indifferent_____

Complaint Information:

Injury Occurred: Work_____ Automobile_____ Third-Party_____ Other_____ Injury Date: _____

Please describe discomfort: _____

Does your pain interfere with Daily Activities? Yes_____ No_____ Is your sleep affected? Yes_____ No_____

Has your pain caused you to miss work? Yes_____ No_____ Approx. how many work days have been missed _____

Has your pain affected your appetite? Yes_____ No_____ Does the weather affect your pain? Yes_____ No_____

What makes your pain worse? _____

What makes your pain better? _____

Have you ever had any X-Ray or MRI for your pain? Yes_____ No_____ If yes, when and where: _____

For Women Only:

Are you pregnant? Yes_____ No_____ Are you taking birth control? Yes_____ No_____

Are you nursing? Yes_____ No_____ Do you experience painful periods? Yes_____ No_____

Are you currently taking hormone replacement therapy? Yes_____ No_____

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Hypothyroid
Arthritis	Depression	Hyperthyroid
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lung Cancer
Back Pain	GERD	Lymphoma
Bone Marrow Transplant	Headache/Migraine	Neck Pain
BPH	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	Hypertension	Seizures
COPD	HIV/AIDS	Stroke
	High Cholesterol	**NONE**

Other:_____

_____

_____

Past Surgical History: (Please circle all that apply)

Appendix Removed: (Appendectomy)
Bladder Removed (Cystectomy)
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colon/Colectomy: Color Cancer Resection
Colon/Colectomy: Diverticulitis
Colectomy: IBD
Colectomy: Colostomy
Gallbladder Removed: (Cholecystectomy)
Heart: Biological Valve Replacement
Heart: CABG (Bypass)
Heart: Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA (Angioplasty)
Joint Replacement, Knee: (Right, Left, Bilateral)
Joint Replacement, Hip: (Right, Left, Bilateral)
Kidney: Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney: Nephrectomy (Right, Left)
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate: Biopsy
Prostate: Cancer
Prostate: TURP (Prostate Removal)
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen
Testicle Removed (Right, Left, Bilateral)
Uterus: (Hysterectomy) Fibroids
Uterus: (Hysterectomy) Uterine Cancer
Uterus: (Hysterectomy) Cervical Cancer
NONE

Other: _____

Medications: (Please enter all current medications & dosage)

_____
_____
_____
_____

Allergies: (Please enter all known allergies)

_____
_____
_____

Social History: (Please circle all that apply):

Cigarette Smoking:
Never smoked
Currently smoke
Has smoked in the past
Former Smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History: (Significant disease & illness, skin or otherwise. Only first degree biological relatives- Mother, Father, Brother, Sister & Children)

CONDITION	RELATIVE

What are your expected outcomes and goals of services that you obtain with Alaska Spine & Pain Center?

_____
_____
_____
_____

I certify that I am the patient or legal guardian as listed in above information. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Alaska Spine and Pain Center. I hereby authorize the provider to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Printed Name:_____ Date:_____

Patient Signature:_____