The Surgery Center Experience

Free Consultation Patient Information Form

Patient Information

Name: _____

Age: _____ M/F: _____

Height: _____ Weight: _____

Phone: _____ Email: _____

City/State: _____ Time Zone: _____

Type of Health Insurance: (Ex: BlueShield PPO) _____

_____

Are you willing to travel? _____

_____

Current Complaint

1) Injury/ Complaint (Body Part / Side (L/R) *(Be as specific as possible. i.e., lumbar, buttocks, groin, upper extremity, lower extremity, etc):* _____
   _____
2) Date of Injury: _____
3) Mechanics of injury: _____
4) Chronic pain / old injury / new injury (choose one): _____
5) Any associated numbness, tingling, weakness? If so, how long? Getting better or worse? ____
   _____
6) Treatment to date: physical therapy, chiropractor, injections, & current medications. How long and how many times? _____
   _____

Previous History

1) Have you seen a doctor? _____
   _____
2) Do you have a MRI or X-ray? _____
3) Are you willing to email or send us the images or reports? _____
   _____

Thank you for your interest in The Surgery Center Experience consultation services. Please do not hesitate to call or email with questions.