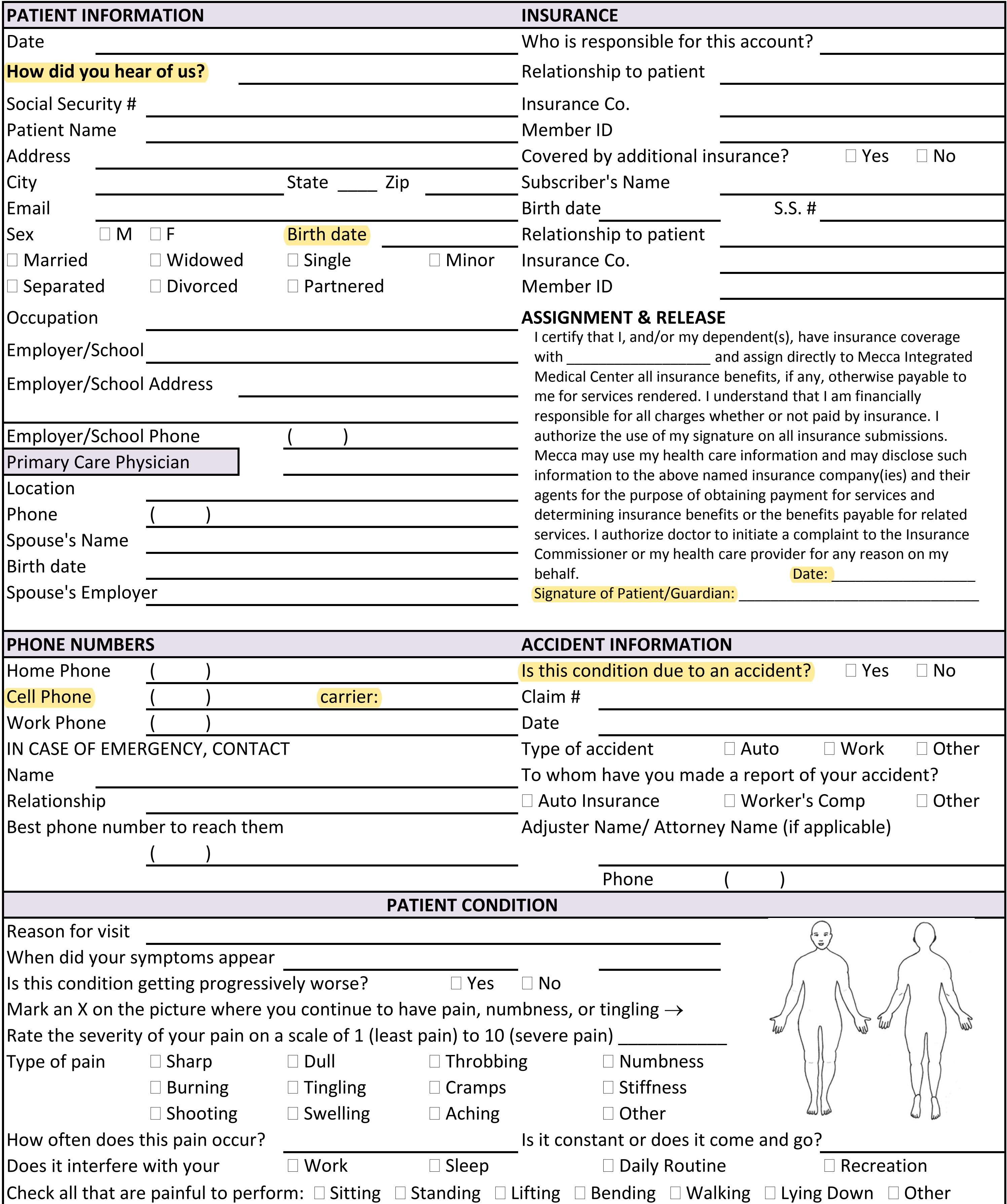

MECCA INTEGRATED MEDICAL

WELCOME

PATIENT INFORMATION

Date ______________________

How did you hear of us? ______________________

Social Security # ______________________

Patient Name ______________________

Address ______________________

City ____________ State _____ Zip ________

Email ______________________

Sex ☐ M ☐ F Birth date ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation ______________________

Employer/School ______________________

Employer/School Address ______________________

Employer/School Phone ( ) ______________________

Primary Care Physician ______________________

Location ______________________

Phone ( ) ______________________

Spouse's Name ______________________

Birth date ______________________

Spouse's Employer ______________________

INSURANCE

Who is responsible for this account? ______________________

Relationship to patient ______________________

Insurance Co. ______________________

Member ID ______________________

Covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birth date ____________ S.S. # ____________

Relationship to patient ______________________

Insurance Co. ______________________

Member ID ______________________

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _________________ and assign directly to Mecca Integrated Medical Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Mecca may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Date: _________________

Signature of Patient/Guardian: ______________________________

PHONE NUMBERS

Home Phone ( ) ______________________

Cell Phone ( ) carrier: ______________________

Work Phone ( ) ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Best phone number to reach them

( ) ______________________

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No

Claim # ______________________

Date ______________________

Type of accident ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Worker's Comp ☐ Other

Adjuster Name/ Attorney Name (if applicable)

____

Phone ( ) ______________________

PATIENT CONDITION

Reason for visit ______________________

When did your symptoms appear ______________________

Is this condition getting progressively worse? ☐ Yes ☐ No

Mark an X on the picture where you continue to have pain, numbness, or tingling →

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) ____________

Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness

☐ Shooting ☐ Swelling ☐ Aching ☐ Other

How often does this pain occur? ______________ Is it constant or does it come and go? ______________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Check all that are painful to perform: ☐ Sitting ☐ Standing ☐ Lifting ☐ Bending ☐ Walking ☐ Lying Down ☐ Other

MEC●CA
INTEGRATED MEDICAL

WELCOME

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Family Doc ☐ Medications
☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Neurology ☐ Pain Management

Date(s) of treatment ______________________

Name and location of other doctor(s) who have treated your condition ______________________

Date of Last:

Physical Exam	________	Spinal X-Ray	________	MRI/CT Scan	________
Spinal Exam	________	Blood Test	________	Bone Scan	________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition		Condition		Condition	
AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mono	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	MS	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Fractures**	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	**Pacemaker**	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Bleeding		Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Disorders	☐ Yes ☐ No	**Herniated Disc**	☐ Yes ☐ No	**Prosthesis**	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	High Blood		Rheumatoid	
Bulimia	☐ Yes ☐ No	Pressure	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	STD's	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Chemical		Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Dependency	☐ Yes ☐ No	Measles	☐ Yes ☐ No	**Tumors/Growths**	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No

Other:

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day ________
☐ Heavy	☐ Heavy Labor	☐ High Stress	Reason ________

Are you pregnant? ☐ Yes ☐ No Due Date

Injuries/Surgeries History

	Description	Date(s)
Falls	________	________
Head Injuries	________	________
Broken Bones	________	________
Dislocations	________	________
Surgeries	________	________

Please List: Max Adult Weight: ________ Min. Adult Weight: ________ Ideal Adult Weight: ________

Medications ______________________

Vitamins/Supplements ______________________

Allergies

ARE YOU READY TO LOSE WEIGHT? (circle one) Yes No