

Jennifer Lakis, D.O. (formerly Jennifer Barrett)

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All Bolded fields on this page are MANDATORY, thanks.

Date: _____

Patient's Legal Name: _____ Name you go by: _____

Date of Birth: ____/____/____ Current Age: _____

Sex: M F Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Primary Phone: _____ type: cell/home/work

Alternate Phone: _____ type: cell/home/work

Email address: _____

Emergency Contact: _____ Phone: _____

Spouse or Parents Name: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: (if different from PCP) _____

Occupation: _____ Employer: _____

Person responsible for payment (if not above) _____

Name and date of birth of Primary cardholder: _____

Phone: _____ Address: _____

City, State, Zip: _____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

Is this a work-related Injury? Y N Has your employer been notified? Y N

Date of Injury: _____ Claim # _____ Adjuster: _____

Adjuster's Phone: _____ Adjuster's Fax: _____

Is this injury a result of an accident? Y N Date of Accident: _____

Claim # _____ Attorney: _____

Please contact your primary care physician to make sure a referral has been sent to us if your insurance carrier requires one. You are fully responsible for payment in the event we do not receive the appropriate insurance referral authorization prior to your date of service. If you have an HMO plan, you most probably do need a referral from your PCP, which would include an insurance provider recognized referral authorization number, number of visits and expiration.

MEDICATIONS: (Include over the counter drugs, supplements and vitamins please.):

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

MEDICAL PROBLEMS:

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

SURGICAL HISTORY:

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

IMAGING STUDIES: (X-Rays, CT scans, MRI's etc.)

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

DENTAL HISTORY:

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

MOTOR VEHICLE COLLISIONS/ACCIDENTS:

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

PREGNANCY HISTORY: Please include: *date, # of weeks of pregnancy, any prenatal problems, the type of delivery: Vaginal/C-Section and any complications during delivery.*

HOME ENVIRONMENT

Who do you live with?: _____

Environmental exposure (Wood smoke, pets, mold, etc....) _____

How is the quality of your home life? _____

EMPLOYMENT

Occupation: _____ Ergonomics: _____

How is the quality of your job? _____

HABITS

	Type	Frequency	#Years	Year quit	Never
Smoking	_____	_____	_____	_____	<input type="checkbox"/>
Alcohol	_____	_____	_____	_____	<input type="checkbox"/>
Drugs	_____	_____	_____	_____	<input type="checkbox"/>
Caffeine	_____	_____	_____	_____	<input type="checkbox"/>

HEALTH MAINTENANCE

Physical activity (type/frequency): _____

Hobbies (type/frequency): _____

Nutrition (tell us about your diet) _____

FAMILY HISTORY

Ethnicity: Hispanic Non-Hispanic Race: _____

	Age	Health Problems	Age at death/cause
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sisters:	_____	_____	_____
Brothers:	_____	_____	_____

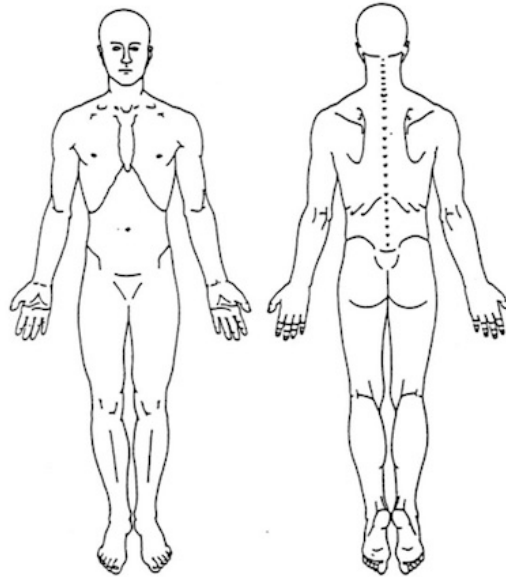
CIRCLE IF PRESENT IN ANY BLOOD RELATIVES: (Include parents, grandparents, brothers, sisters children, cousins, aunts and uncles)

- Diabetes Heart Disease High Blood Pressure Lung Disease Tuberculosis Epilepsy
- Migraines Arthritis Depression Glaucoma Suicide Kidney Disease
- Blood Disease Obesity Chronic Muscle Pain Thyroid Disease Ruptured Disc
- Alcoholism Cancer (type) Other: _____

LOCATION OF PAIN:

Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

- “N”=Numbness
- “S”=Stabbing
- “B”=Burning
- “P”=Pins and needles
- “A”=Aching Pain



How did your current episode begin? Suddenly Gradually

Describe the onset of the pain:

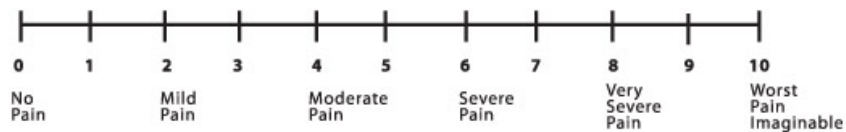
How long ago did the current episode begin? _____

Has the pain lessened, stayed the same, or worsened? _____

What does the pain feel like? (circle all that apply):

- | | | | | |
|-------------------|-----------|-----------|--------------|-------------|
| Throbbing | Splitting | Shooting | Stabbing | Hot/Burning |
| Tiring/Exhausting | Aching | Sickening | Sharp | Heavy |
| Tender | Gnawing | Cramping | Other: _____ | |

How bad is your pain **Today**, on a scale of 0-10 with 0 being no pain, and 10 being the worst pain imaginable.



Which number (0-10) describes your pain at its worst? _____

Have you consulted any other healthcare practitioner for pain relief of your current problem? If so, please list:

Please mark all the following treatments that you have used for pain relief:

	Helped Pain	worsened pain	no change
massage therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hot packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brace support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
injection therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mark the effect of each of the following on your pain:

	Increases	Decreases	No change
sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coughing/sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE MARK ALL THAT APPLY:

GENERAL

- Weight Gain or Loss
- Change in Appetite/Thirst
- Fatigue
- Weakness
- Change in Sleep Patterns
- Fever
- Chills
- Night Sweats
- Cold Intolerance
- Change in Hair/Skin
- Easy Bruising
- Irritability/Indifference

HEAD/ EYES/ EARS/ NOSE/ THROAT

- Eye Pain/Disease
- Visual Problems/ Wears Glasses
- Ear Pain/ Frequent Ear Infections
- Ringing in Ears
- Hearing Problems
- Chronic Sinusitis
- Nasal Discharge
- Difficulty Swallowing
- Sore Throat
- Swollen Glands

SKIN

- Itching
- Psoriasis/Eczema
- Lumps
- Change in Moles/ Warts/ Lesions
- History of Cancer
- Other Rash

MUSCULOSKELETAL DISEASE

- Joint Pain
- Redness
- Swelling
- Stiffness
- Frequent/Severe Muscle Pain
- Weakness
- Disc Herniation
- Abnormal Spinal Curve
- Workers Comp Injuries

GASTROINTESTINAL

- Nausea/Vomiting

- Abdominal Pain
- Ulcer
- Heartburn
- Reflux
- Hiatal Hernia
- Change in Bowel Habits
- Irritable Bowel Syndrome
- Excessive Gas
- Food Intolerance
- Crohns
- Ulcerative Colitis
- Liver/Gall Bladder

RESPIRATORY

- Wheeze
- Asthma
- Use of Inhalers
- Shortness of Breath
- Frequent Cough
- Bronchitis
- COPD
- Pneumonia
- Flu
- Respiratory Syncytial Virus

URINARY

- STD'S
- Frequent UTI
- Pain with Urinating
- Incontinence
- Kidney Stones

NERVOUS SYSTEM

- Seizures
- Tremors
- Headaches
- Head Injury
- Numbness/Tingling
- Loss of Coordination
- Dizziness/Vertigo
- Poor Memory
- Stroke/TIA
- Fainting
- Change in Taste or Smell
- Neurological Disease

BLOOD/LYMPH

- Anemia
- Bleeding
- Jaundice

PSYCHOLOGICAL/ENDOCRINE

- Often Nervous/Worries
- PTSD
- Constant Feelings of Sadness/Hopelessness
- Hospitalized for Mental Illness
- Psychological Diagnosis
- Decreased Sense of Well-Being/Energy
- Decreased Mental Sharpness/Forgetful
- History of Thyroid Disease

FEMALE

ENDOCRINE/REPRODUCTIVE

- Sexual Dysfunction
- Decreased Desire
- Pain with Intercourse
- Menstrual Irregularity/Flow
- Bloating
- PMS
- Endometriosis
- Fibroids
- Infertility
- Miscarriages
- Menopausal
- Perimenopausal
- Breast Lumps/Irregularity

MALE

ENDOCRINE/REPRODUCTIVE

- Erectile Dysfunction
- Sexual Dysfunction
- Decreased Desire
- Prostate Disease
- Infertility

CARDIOVASCULAR

- Angina
- Palpitations
- Arrhythmia
- Heart Murmurs
- Blood Vessel Disease
- Clots
- Thrombophlebitis
- Foot/Ankle Swelling
- Heart Attack
- Heart Failure
- Chest Pain
- HBP

ALLERGIES

MARK ALL THAT APPLY:

- No known FOOD allergies
- No known DRUG allergies
- No known ENVIRONMENTAL allergies

IF YOU HAVE AN ALLERGY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

1. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficulty Speaking/Swallowing
- Loss of Consciousness
- Fast/Slow/Irregular Heartbeat
- Chest Pain

2. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficulty Speaking/Swallowing
- Loss of Consciousness
- Fast/Slow/Irregular Heartbeat
- Chest Pain

3. Medication/Food/Other: _____ Start Date: _____

Reaction: Mild Moderate Severe Very Severe

Abdominal:

- Pain/Cramping
- Bloating/Gas
- Vomiting
- Diarrhea
- Nausea

Skin:

- Rash (localized)
- Rash (general)
- Itchiness
- Patchy/Swelling
- Facial Swelling
- Hives

Local:

- Conjunctivitis
- Runny Nose
- Cough

Systemic:

- Shortness of Breath
- Wheezing
- Dizziness
- Swelling Tongue
- Difficult Speech/Swallowing
- Loss of Consciousness
- Irregular Heartbeat
- Chest Pain

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- **NOTICE OF ACKNOWLEDGEMENT:** I acknowledge that I have received the notice of privacy practices posted in the office. I understand that a copy of our privacy practices is available to me upon request.

- Signature: _____ Date: _____
- Print Name: _____ DOB: _____

- **AUTHORIZATION OF PAYMENT:** I authorize payment of my medical benefits to Jennifer Lakis, D.O. for services rendered. I understand that I am financially responsible in the event that payment is denied or rejected by the insurance company and for those charges not covered by policy benefits, as well as deductibles and co-insurance that are not covered by this assignment.

- Signature: _____ Date: _____

- **RELEASE OF NECESSARY MEDICAL INFORMATION:** During the course of my treatment I understand that certain tests, such as an MRI, CT Scan, or consultations with other physicians may be necessary. I authorize the release of any medical information for these purposes. I authorize the release of any medical information for these purposes. I authorize the release of any medical information necessary to process my disability and/or medical claim.

- Signature: _____ Date: _____

- **LATE CANCEL AND NO-SHOW POLICY:** All patients are granted one late cancel without additional charge per calendar year. There is a \$25 charge for any appointment cancelled less than 24 hours of the scheduled time. There is a \$100 charge for any no-show to an appointment. I understand that arriving more than fifteen minutes late for any scheduled appointment will be considered a no-show and treatment is not guaranteed.

- Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

- **MEDICARE RELEASE OF NECESSARY MEDICAL INFORMATION:** I authorize any holder of medical or other information about me to be released to the social security administration, health care financial administration or it's intermediaries/carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments, I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatments of any changes. (Section 1128(B) of the social security act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

- Signature: _____ Date: _____

FOR OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORTS: the patient presented for treatment on this date and was provided with a copy of the notice of privacy practices. A good faith effort was made to obtain a written acknowledgement or receipt of the notice. However, an acknowledgement was not obtained for the following reason: _____ Patient name:

Signature of physician or employee: _____ Date: