Dr. Patrick O'Shea

11468 Sorrento Valley Road, Suite A •San Diego, CA 92121
(858)457-3545 • Fax (858) 457-0976 •www.advancedsofttissuecare.com

Name: ______________________________ Date: ________________________

Welcome! We look forward to serving you. As a new patient with our office, we would like you to be familiar with our office policies concerning your scheduling and account while you are with us. Please feel free to ask any questions regarding the following.

1. We require a 24-hour notice during business hours to change or cancel a scheduled appointment. If you fail to show or cancel your appointment without a 24-hour notice you will be charged for the appointment time you scheduled ***($95.00 for 20 minute appointment, $190.00 for a 40 minute appointment***). Payment is due before your next appointment. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier.

2. Our office does not directly bill insurance. However, we would be happy to provide you with a patient ledger/superbill so that you can submit it to your insurance company.

3. In the event any action is taken to enforce collection of this account, the presiding party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature ______________________________________ Date ______________________

Witness ______________________________________ Date ______________________

Please use the back of page for additional writing space as needed.

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Patient Information

☐ New Patient ☐ Old patient

Referred By	Physician's Name	Date

Patient Name (Last, First, Middle Initial)				E-mail Address		
Home Address				City	State	Zip
Home Phone		Work Phone		Extension	Cell Phone	
Sex M F	SS# - -		Birthday		Drivers License #	

Check Appropriate Box:

☐ Work Related Injury ☐ Auto Accident ☐ Reoccurring Injury ☐ Other

☐ Private Injury ☐ Student Athletic Injury ☐ On-campus Injury ☐ Surgery

Patient Employer	City
Student? **Y** **N** ☐ Full Time ☐ Part Time	School Name

In Case of Emergency, Please Notify:	Phone	Relationship	
Address	City	State	Zip
If Patient is a Minor, name of Responsible Party		Phone # of Responsible Party	

________ Initial — I hereby authorize Dr. O'Shea to release any information regarding my medical condition to the attending or referring medical practitioner.

________ Initial — I direct that payments be made directly to Dr. O'Shea. I understand that I am financially responsible for all charges on the date of service.

Signature of Patient or Responsible Party	Date

Please use the back of page for additional writing space as needed.

Patient Intake Questionnaire

Date: ____________________

Patient's Name: ______________________________

Age: ___________ Sex: _____________

DR. PATRICK O'SHEA, D.C.
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About your current complaint:

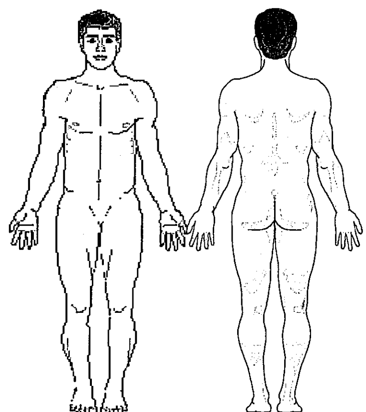
1. What is the complaint that brought you here? ____
2. When did this complaint begin, or recently become worse? Approximate Date: ______________________
3. What caused this complaint? ____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: ☐ Yes ☐ No

   If "Yes", what activities? ____
5. What makes this complaint better? ____
6. Does this complaint affect your comfort, mood, or ability to sleep? ☐ Yes ☐ No
7. What symptoms are you experiencing with this complaint?

   ☐ Swelling ☐ Loss of balance or coordination

   ☐ Loss of motion ☐ Numbness ☐ Pain: Draw pain areas on body diagrams ->

   ☐ Weakness ☐ Tingling ☐ Other (Specify)



8. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent
9. How much pain are you experiencing?

   ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
10. What tests have you had for this complaint?

    ☐ X-ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan
11. What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy

    ☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine-(Specify): ______________________
12. Is this complaint work related? ☐ Yes ☐ No

    If "Yes", your employer's name: ______________________ Your Occupation: ______________________

    Work Status: ☐ Full Time ☐ Part Time ☐ Working ☐ Medical Restrictions ☐ Medical Leave Last Date Worked: _________
13. Is this complaint auto related? ☐ Yes ☐ No

About your general health:

14. Please check all medical conditions that you have, or have had.

    ☐ Arthritis ☐ Heart Disease ☐ Stomach Disorder ☐ Headaches ☐ Pace Maker

    ☐ Cancer ☐ High Blood Pressure ☐ Anxiety ☐ Dizziness ☐ Other: __________

    ☐ Diabetes ☐ Lung Disease ☐ Depression ☐ Metal Implants

    ☐ Stroke/Seizure ☐ Thyroid Problems ☐ Panic Attacks ☐ Morning Stiffness
15. Please check all of the following items that currently apply to you.

    ☐ Hearing Problem ☐ Visual Problems ☐ Learning Problems

    ☐ Pregnant ☐ Bowel or bladder control ☐ Smoker ☐ Recent weight loss
16. Please list surgeries: ____
17. Please list allergies: ____
18. Please list medications you are currently taking: ____

    ____
19. What goals do you want to achieve through your treatment Dr. O'Shea? ______________________

    ____

Please use the back of page for additional writing space as needed.