

Personal Information

Name _____

Address _____ City _____ State _____ Zip _____

SSN# xxx-xx- _____ Date of Birth _____ Marital Status: S M W D

Home Telephone _____ Cell _____ Work _____

Email _____ Best Place To Reach You (circle one) Home/Work/Cell

Occupation _____ Employer _____

Spouse/Significant Other's Name _____ Phone _____

Emergency Contact: Name _____ Relationship _____ Phone _____

I (signature) _____ consent to allow Dr. Ball to speak with me
and perform a consultation and examination in order to determine if further testing is necessary.

Please answer the following questions.

What are you hoping happens today as a result of your consultation with the Doctor? _____

Since your problem began, what three things has it caused you to miss the most?

1. _____
2. _____
3. _____

What are you hoping Dr. Ball tells you today? _____

Describe what you hope or think Dr. Ball might be able to do for you. _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

Describe what will be different/better in your life if you can finally be relieved of these problems. _____

What is your idea of the ideal doctor? _____
