

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Height _____ Weight _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Widowed Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Email Address _____

May we contact you by Email for appointment reminders and information about our services?

Yes No

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Newspaper Location Other _____

Payment for Services will be by: Cash Health Insurance Automobile Insurance

Worker's Compensation

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F	S	M	F	S	M	F			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	dislocated joints	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	epilepsy	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	German measles	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	headaches	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	heart trouble	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	reproductive disorders	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	high blood pressure	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	meningitis	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	kidney disorder	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	bowel control loss	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	menstrual cramps	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	multiple sclerosis	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	muscular dystrophy	hernia

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

(continued on next page)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms on a scale of 1-10 (1 is least severe & 10 is most severe)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

SYMPTOMS ARE WORSE IN MORNING DURING DAILY ROUTINE NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT

ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? _____

NAME OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES

WHAT KIND? _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD

LIFTING SNEEZING WALKING LYING DOWN STANDING GETTING UP & DOWN

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion constipation

depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too

heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to

colds muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in

legs ringing in ears shortness of breath stiff neck stomach upset

Patient's Signature: _____ Date: _____