Confidential Patient Data

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

PATIENT INFORMATION

Today's Date:_____

Name:_____ Date of Birth:_____ Height_____ Weight_____

Address:_____ City:_____ State:_____ Zip:_____ Email:_____

Home Phone:_____ Work Phone: _____ Cell phone_____

Age:_____ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

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

❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance

❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.:_____ Insured's Employer: _____

Insured's Social Security #:_____ Employer's Phone #:_____

Are you covered by more than one insurance company? ❑Yes ❑No Name _____

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	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

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:_____

(over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1 being least serious)

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

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑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 AND LOCATION 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

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:_____