Confidential Patient Data

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

PATIENT INFORMATION

Today's Date:_____

Name:_____
D.O.B:_____Address:_____
City:_____ State:____Zip:_____ Email:_____

Home Phone:_____Work Phone: _____
Mobile Phone:_____
Social Security #:_____ 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 _____

PERSONAL MEDICAL HISTORY

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

❑ 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	❑ 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:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

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

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

Office use only
Diag codes
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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:_____