Confidential Patient Data

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

PATIENT INFORMATION

Today's Date: _____

Name: _____
Address: _____
City: _____ State: ____Zip:_____ Email: _____

Home Phone: _____Work Phone: _____
Mobile Phone: _____
Date of Birth: _____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? _____
❑Insurance ❑Internet/Webpage ❑Yellow Pages ❑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 Date of Birth: _____
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	❑ depression	❑ HIV/ARC	❑ reproductive disorders
❑ allergies	❑ diabetes	❑ kidney disorder	❑ rheumatic fever
❑ anemia	❑ diarrhea	❑ loss of bowel control	❑ scarlet fever
❑ arthritis	❑ digestive disorders	❑ lung disease	❑ scoliosis
❑ asthma	❑ dislocated joints	❑ menstrual cramps	❑ serious injury
❑ back pain	❑ epilepsy	❑ multiple	❑ sinus trouble
❑ bladder trouble	❑ fibromyalgia	❑ muscular dystrophy	❑ stroke
❑ bone fracture	❑ German measles	❑ neck pain	❑ thyroid problems
❑ cancer	❑ headaches	❑ nervousness	❑ ulcers
❑ chest pain	❑ heart trouble	❑ numbness	❑ venereal disease
❑ concussion	❑ hepatitis	❑ osteoporosis	
❑ constipation	❑ high blood pressure	❑ polio	
❑ convulsions	❑ high cholesterol	❑ poor circulation	

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

Diagnostic codes

_____
_____
_____
_____
_____
_____
_____
Onset_____

DATE SYMPTOMS BEGAN:_____

HOW DID SYMPTOMS START?_____

_____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET

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:_____