

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

**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: \_\_\_\_\_