Confidential Patient Data

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

PATIENT INFORMATION

Name: _____
Date of Birth: _____

Address: _____ **City:** _____ **State:** _____
Zip: _____

Home Phone: _____ **Work 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 Company: _____ **Insured's Employer:** _____
Insured's Social Security #: _____ **Employers Phone #:** _____
Are you covered by more than one insurance company? ☐ Yes ☐ No
If yes, What companies _____

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	☐	☐	☐	hepititis
☐	☐	☐	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	☐	☐	☐	nemreal 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 **Ever been gunshot?** ☐ 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 symptom from 1 - 10 (1=leastsevere)

	Symptom	Rating
1.		
2.		
3.		
4.		
5.		
6.		

SYMPTOMS ARE WORSE IN ☐ MORNING ☐ AFTERNOON ☐ NIGHT

WHEN AND HOW OCCURRED

SYMPTOMS DEVELOPED FROM: ☐ Job Related ☐ Auto Accident ☐ Other ☐ Accident
☐ Illness ☐ Unknown ☐ Gradual Onset DATE OCCURRED: _____
SYMPTOMS HAVE PERSISTED FOR # ☐ Hour(s) ☐ Day(s) ☐ Week(s)
☐ Month(s) ☐ Year(s)
SYMPTOMS/COMPLAINTS: ☐ Come and 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 Menstual 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:_____