Confidential Patient Data

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

PATIENT INFORMATION Today's Date:_____

Name:_____ ☐ Male ☐ Female

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

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Social Security #:_____ Date of Birth:_____ Age:_____

Email Address:_____

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 ☐Newspaper ☐Doctor_____ ☐Other_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint 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	☐	☐	☐	Venerea disease

Do you have a family physician? ☐Yes ☐No Physician's Name:_____

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:_____

(Turn Page Over)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

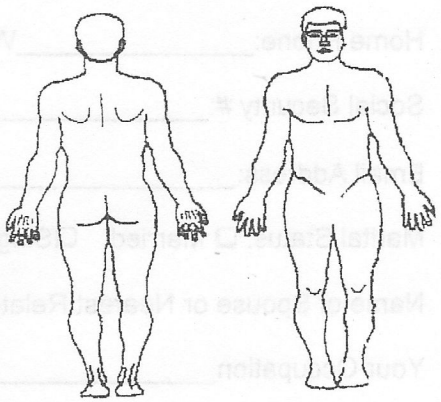
Please Rate Your symptoms(1-10, with 1 being least serious)

1._____ _____

2._____ _____

3._____ _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:



Aches^^^^ Numbness °°°° Pins/Needles •••• Stabbing ////

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

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 AND FOR WHAT CONDITION?
_____
_____

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 ❑stomach upset
❑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

Patient's Signature:_____ Date:_____