"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." - **Thomas Edison**

CONFIDENTIAL PATIENT INFORMATION

DATE:_____

Thank you for choosing our practice for your health needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT:

Last Name: _____ First Name: _____ Middle: _____

Gender: □M □F Date of Birth: ____/____/_____ Age: _____ SS#: _____

Are you: □Minor □Married □Divorced □Widowed □Single □Separated

How Many Children? □0 □1 □2 □3 □4 □5-10 □more than 10 ☺

Home Address: _____ Apt#: _____

City: _____State: _____ Zip: _____

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

Email Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____State: _____ Zip: _____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____ Middle: _____

Employer Name: _____ Work Phone #: _____

Date of Birth: ____/____/_____ SS#: _____

Whom may we thank for referring you to us? _____

EMERGENCY Name and address of nearest relative or friend ***not living with you***:

Last Name: _____ First Name: _____ Middle: _____

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

Relation to Patient: _____

INSURANCE: □Yes □No

Name of Insurance: _____

Name of Insured: _____ Relationship to patient: _____

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

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

Employer Name: _____ Occupation: _____

SIGNATURE (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____

SYMPTOMS Reason for visit: _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? □Yes □No □Same □Better

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? □Sitting □Standing □Walking
□Bending □Lying down □Other _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting
□Burning □Tingling □Cramps □Stiffness □Swelling □Other _____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain):
□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

How frequent is the condition? □Constant □Daily □Intermittent □Night Only

Is there anything you can do to relieve the problem? □Yes □No If yes, describe, _____

Have you ever had the same or a similar condition? □Yes □No If yes, when, _____

List any major accidents you have had? _____

What treatment have you already received for your condition?
□Medication □Surgery □Physical Therapy □Other _____

Name and address/phone numbers of other doctor(s) who have treated you for your condition:
_____

HEALTH HISTORY

Check only those conditions which are applicable:

□AIDS/HIV	□Cataracts	□Hepatitis	□Osteoporosis	□Suicide Attempt
□Alcoholism	□Chemical Dependency	□Hernia	□Pacemaker	□Thyroid Problems
□Allergy Shots	□Chicken Pox	□Herniated Disc	□Parkinson=s Disease	□Tonsillitis
□Anemia	□Depression	□Herpes	□Pinched Nerve	□Tuberculosis
□Anorexia	□Diabetes	□High Cholesterol	□Pneumonia	□Tumors, Growths
□Appendicitis	□Emphysema	□Kidney Disease	□Polio	□Typhoid Fever
□Arthritis	□Epilepsy	□Liver Disease	□Prostate Problems	□Ulcers
□Asthma	□Fractures	□Measles	□Prosthesis	□Vaginal Infections
□Bleeding Disorders	□Glaucoma	□Migraine Headache	□Psychiatric Care	□Venereal Disease
□Breast Lump	□Goiter	□Miscarriage	□Rheumatoid Arthritis	□Whooping Cough
□Bronchitis	□Gonorrhea	□Mononucleosis	□Rheumatic Fever	□Other _____
□Bulimia	□Gout	□Multiple Sclerosis	□Scarlet Fever	_____
□Cancer	□Heart Disease	□Mumps	□Stroke	

Name of Family Physician: _____ May we contact: □Yes □No

Physician Phone Number & Address: _____

Date of last exams: _____

(Women) Are you pregnant? □Yes □No Nursing? □Yes □No Taking birth control pills? □Yes □No

List any types of surgeries which you have had and the dates which they occurred:
_____

Please list all medications you are currently taking: _____

Allergies: _____

DAILY HABITS

What type of exercise do you perform on a daily basis? □None □Moderate □Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)
_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? □Yes □No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____