Confidential Patient Data

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

PATIENT INFORMATION

Today's Date:_____

Name: _____ Nickname: _____

❑ Male ❑ Female Date of Birth: _____ SSN: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other _____

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

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

Email: _____ How would you prefer we reach you? _____

How will you pay? ❑ Self Pay ❑ Health Insurance ❑ Auto Insurance ❑ Worker's Compensation

Name of Insurance Co.: _____ Insurance ID# _____

Group # _____ Insurance Phone #: _____

Are you covered by a secondary insurance? ❑ Yes ❑ No Name of Secondary Ins._____

Your Occupation: _____ You're Employer: _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Referred to this Office by: ❑ Friend/Family Member – Name? _____

❑ Yellow Pages ❑ Mail ❑ Clinic Location ❑ Other: _____

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	❑	❑	❑	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	❑	❑	❑	Venereal Disease

Are there any other disorders not listed about that apply to you? _____

_____

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: _____ 3._____ Date: _____

2._____ Date: _____ 4._____ Date: _____

Have you ever had a metal implant? ❑ Yes ❑ No If yes, Where? _____

ACCIDENT HISTORY ❑ Job ❑ Auto ❑ Other 1._____ Date: _____

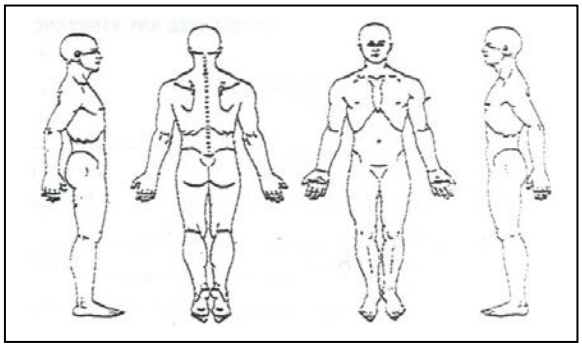
❑ Job ❑ Auto ❑ Other 2._____ Date: _____

❑ Job ❑ Auto ❑ Other 3._____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

PLEASE RATE YOUR SYMPTOMS (1-10, WITH 10 BEING YOUR MOST INTENSE PAIN)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____



Symptoms are worse in: ❑Morning ❑Afternoon ❑Night

When and how did this occur? _____

_____

Symptoms Developed from: ❑ Job Related Injury ❑Auto Accident ❑Other ❑Illness
❑Other Incident ❑Unknown Cause ❑Gradual Onset Date Occurred: _____
Symptoms Persisted for: _____ Hour(s) _____ Day(s) _____Week(s) _____ Month(s) _____Year(s)
Symptoms/Complaints: ❑Come & Go ❑Constant
Have you ever had this before? ❑No ❑Yes
When?_____
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 Cycle? _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑Bending ❑Reaching ❑Coughing ❑Sitting ❑Turning/Twisting ❑Lifting ❑Sneezing
❑Walking ❑Lying Down ❑Standing
❑Other:_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑Bending ❑Sitting ❑Lifting ❑Standing ❑Lying Down ❑Turning/Twisting ❑Reaching
❑Walking
❑Other:_____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑Blurred Vision	❑Weeping Spells	❑Insomnia	❑Pins and Needles in Arms
❑Buzzing in Ears	❑Diarrhea	❑Light Bothers Eyes	❑Pins and Needles in Legs
❑Cold Feet	❑Dizziness	❑Loss of Balance	❑Ringing in Ears
❑Cold Hands	❑Face Flushed	❑Loss of Smell	❑Shortness of Breath
❑Cold Sweats	❑Fainting	❑Loss of Taste	❑Stiff Neck
❑Concentration Loss	❑Fatigue	❑Low Resistance to Colds	❑Upset Stomach
❑Confusion	❑Fever	❑Muscle Jerking	
❑Constipation	❑Heavy Head	❑Numbness in Fingers	
❑Depression	❑Headaches	❑Numbness in Toes	

Patient Signature:_____ **Date:**_____