

# 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: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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 Co.: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Insured's

Social Security #: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

**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"/>	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"/>	HIV/ARC	<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"/>	serious injury
<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"/>	tuberculosis
<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"/>	venereal 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 symptoms(1-10, with 1 being least serious)

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
6. \_\_\_\_\_

SYMPTOMS ARE WORSE IN MORNING AFTERNOON 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?

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NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

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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

**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 /con-  
fusion 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:\_\_\_\_\_