

# Confidential Patient Data

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Today's Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Received by: \_\_\_\_\_

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
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:  Yellow Pages  Mail  Clinic Location  
 Friend/Family Member - Name? \_\_\_\_\_

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: \_\_\_\_\_  
For Auto: Cross-streets and City, State \_\_\_\_\_  
 Job  Auto  Other 2. \_\_\_\_\_ Date: \_\_\_\_\_  
For Auto: Cross-streets and City, State \_\_\_\_\_  
 Job  Auto  Other 3. \_\_\_\_\_ Date: \_\_\_\_\_  
For Auto: Cross-streets and City, State \_\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Please List Your Complaints:

Rate it 1-10, with 1 being least serious? How Long?

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

**SYMPTOMS ARE WORSE IN** MORNING AFTERNOON NIGHT CONSISTANT UNCHANGED

**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?**

\_\_\_\_\_

**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 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:** \_\_\_\_\_