



## Confidential Patient Data

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

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:**

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, (10 as the worst and 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? \_\_\_\_\_

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: \_\_\_\_\_