CONFIDENTIAL PATIENT INFORMATION

Date _____

Who Referred You?_____ E-Mail _____

Name_____

Address _____ City _____ State ___ Zip _____

Home Phone (___) _____ Cell Phone (___) _____ Age _____ Birthdate_____

Social Security # _____Occupation _____ Employer _____

Employer's Address _____ City _____ State ____ Zip _____

Drivers Lic. # _____ Marital Status _____ Number of Children_____

Name of Spouse _____ Spouse Occupation _____ Employer_____

Emergency Contact Person _____ Phone Number_____

Describe Your Condition/Complaint ? _____

_____

How long have you had this complaint? _____ Have you experienced this before?_____

List other Doctor(s) seen for this condition _____

Is your health problem work related ? ☐YES ☐NO As a result of an auto accident ? ☐ YES ☐NO

[PLEASE FILL OUT THE FOLLOWING IF DUE TO WORK OR AUTO ACCIDENT]

Date of accident _____ Hour of accident _____ AM PM

WORK RELATED INJURY

Was any equipment, machinery and or object(s) related to injury? ☐ YES ☐NO What kind ?_____

Was accident reported to supervisor and/or employer ? ☐YES ☐NO

Has a Worker's Compensation claim been filed ? ☐YES ☐NO

TRAFFIC ACCIDENT

What kind of vehicle was involved in accident ? ☐TRUCK ☐CAR ☐MOTORCYCLE ☐OTHER

Were you a ☐DRIVER ☐PASSENGER ☐PEDESTRIAN ?

Were there others involved in the vehicle with you ?☐YES ☐NO Who are they ? _____

Was your vehicle moving when the accident occurred ?☐YES ☐NO Approximate MPH ? _____

Did your vehicle hit other vehicle(s) ? ☐YES ☐NO Where ? _____

Did other vehicle(s) hit your vehicle(s) ? ☐YES ☐NO Where ? _____

Was accident reported to the POLICE DEPARTMENT ? ☐YES ☐NO

Were traffic citations issued? ☐YES ☐NO To whom ? _____

Describe accident including cause(s) and surrounding circumstance _____

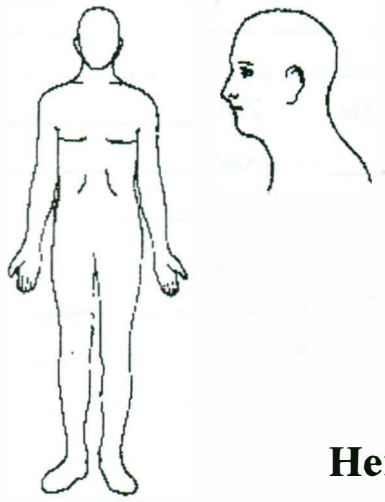
_____

_____

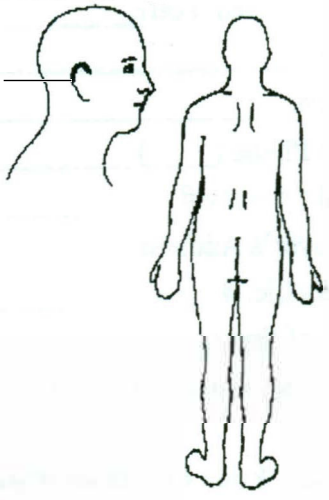
_____

PATIENT PAIN DRAWING

Please place the symbol(s) on the body in the area(s)
that best describes your pain or discomfort you are experiencing.



Z =	SHARP PAIN
D =	DULL PAIN
B =	BURNING PAIN
N =	NUMBNESS
T =	TINGLING
A =	ACHE
P =	PINS & NEEDLES
X =	THROBBING



Height:_____ **Weight**:_____

SYMPTOMS: Circle those you **Presently** (during the last few weeks) have. **UNDERLINE** those you have had previously.

GENERAL
- ☐ Headache
- ☐ Head seems too heavy
- ☐ Shoulders feel heavy
- ☐ Loss of memory
- ☐ Equilibrium Problems
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremors
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck motion restricted
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Pins/needles in arm/legs
- ☐ Arm/leg numbness
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Extreme nervousness
- ☐ Tension
- ☐ Anxiety
- ☐ Fatigue

Fever
- ☐ Chills
- ☐ Sweats
- ☐ Loss of Sleep
- ☐ Allergies
- ☐ Nausea

EAR,NOSE,THROAT
- ☐ Failing vision
- ☐ Nearsightedness
- ☐ Far sightedness
- ☐ Blurred vision
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Sinus infection
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Gum disease

- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Enlarged glands

SKIN
- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Boils
- ☐ Moles
- ☐ Varicose veins
- ☐ Sensitive skin

RESPIRATORY
- ☐ Chronic cough
- ☐ Spitting phlegm
- ☐ Spitting blood
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Shortness of breath

CARDIOVASCULAR
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart problems
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection/stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate problems
- ☐ Hernia

GASTROINTEST.
- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Excessive thirst/hunger
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems

FOR WOMEN
- ☐ Painful menst. periods
- ☐ Cramps or backache
- ☐ Irregular cycle
- ☐ Excessive Flow
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Hot flashes
- ☐ Pregnant ☐ Yes ☐ No
- ☐ Breast implants

DISEASE PROCESSES: Please **Circle** if you now have, or have had, any of the following:

☐Cancer	☐Multiple Sclerosis	☐Immunity Disease
☐Diabetes	☐Measles	☐Osteoporosis
☐Heart Disease	☐Epilepsy	☐Transient Ischemia Attack
☐Tuberculosis	☐Convulsions	☐Fractures
☐Hepatitis	☐Concussions	☐Dislocations
☐High Blood Pressure	☐Rheumatism	☐Asthma
☐Stroke	☐Rheumatic Fever	☐Venereal Disease
☐Muscular Dystrophy	☐Scarlet Fever	☐Meningitis
☐Systemic Lupus Erythmetosis	☐Scleraderma	☐Psoriasis
☐Diptheria	☐Pneumonia	☐Polio
☐Typhoid Fever	☐Anemia	☐Alcoholism

PAST HEALTH HISTORY

SURGERIES: Please **Circle** applicable items: ☐Appendix, ☐Rectal ☐Tonsils, ☐Hernia, ☐Joints, ☐Heart, ☐Spine, ☐Gall Bladder, ☐Female Organs, ☐Prostate, ☐Implants

Other Surgical Procedures: _____

Other Injuries (slips, falls, auto, etc.): _____

List medications you are currently taking, prescription/over the counter: _____

Do you smoke? ☐YES ☐NO How much per day? _____

FEMALES: Are you taking Birth Control Pills? ☐YES ☐NO How long have you been on them? _____

FINANCIAL ARRANGEMENTS

Will You Be Using Insurance? ☐YES ☐NO Primary Insurance Company _____

Secondary Insurance Company (Spouse's Insurance) _____

Please present your insurance card(s) to us

With my signature below, I voluntarily Consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the Doctor and it is the responsibility of the staff to carry out any instructions of the Doctor. I hereby authorize the doctor to treat my condition as he deems appropriate. Any x-rays taken at this office are property of this office, being on file where they may be seen at any time.

I understand that health and accident insurance policies are and arrangement between an insurance carrier and me, the patient. It is my responsibility to provide my insurance information (if applicable) and any other information needed to submit claims for my treatment. I understand that I am responsible for any services rendered to me, including deductibles, co-pays. Or non-covered services. Payment of services, co-pays, deductibles and non-covered services are expected at the time of service.

I have read, understand and agree with the above policies.

_____

Print Patient Name

_____ _____

Patient signature ***Date***