# 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: ______________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 _________________

## A d d i t i o n a l P a t i e n t I n f o r m a t i o n

Are you currently taking any medications? (Please circle one) Yes No

If yes, please list

_____________________ ____________________ _____________________

_____________________ ____________________ _____________________

_____________________ ____________________ _____________________

Are you allergic to any medications? (Please circle one) Yes No

If yes, please list

_____________________ ____________________ _____________________

_____________________ ____________________ _____________________

What is your race? (Please circle one)

White Black or African American Asian American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander Other Race More Than One Race

What is your ethnicity? (Please circle one)

Hispanic or Latino Not Hispanic or Latino

What is your preferred language?

English Spanish French German Italian Russian

Portuguese Chinese Japanese Korean Vietnamese

What is your smoking status? (Please circle one)

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

What is your preferred method of communication for private health data? (Please circle one)

Home Phone __ Work Phone__ Mobile Phone__ e-Mail __ Standard Mail__

## 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 |

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 heart operation or pace maker? ❑Yes ❑No

ACCIDENT HISTORY

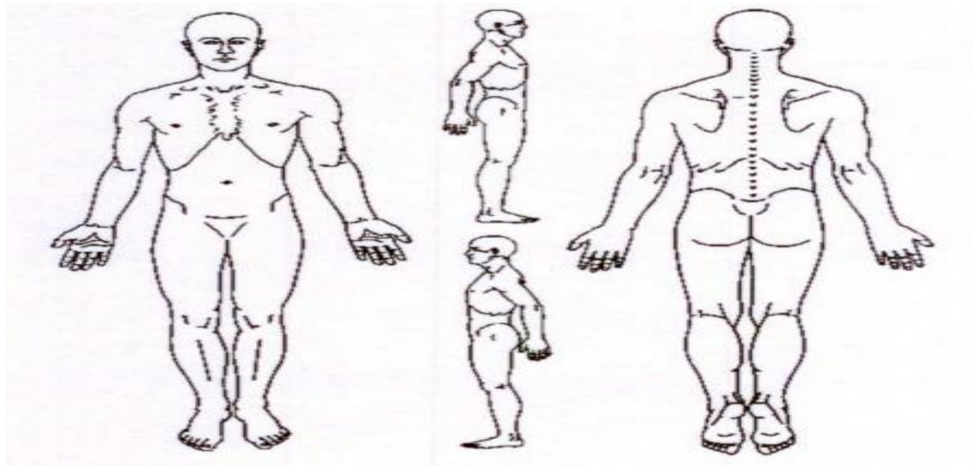
❑Job ❑Auto ❑Other 1. __________________________Date:________________

❑Job ❑Auto ❑Other 2.__________________________Date:________________

❑Job ❑Auto ❑Other 3.__________________________Date:________________

## PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: circle body areas

Please Rate Your symptoms 1-10, with 1 is the least serous, 10 is the worst.



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

Other:_______________________________________________________________________

Patient's Signature:____________________________________ Date:_______________________