



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: _____