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: ______________

PHONE NUMBERS (Home): ______________ (Work): ______________ Other: ______________

☐ MALE ☐ FEMALE MARTIAL STATUS: ______________

OCCUPATION: ______________________ EMPLOYER: ______________________

Referred to this office by: ☐ Friend/Family Member Name? ______________________

☐ Event or advertisement ______________________

Payment for services will be paid by: ☐ Cash ☐ Check ☐ Credit Card ☐ Medicare ☐ Automobile Insurance ☐ Worker's Compensation

MEDICAL/FAMILY HISTORY

S=Self M=Mother F=Father (Please indicate which conditions have been experienced by person by marking appropriate boxes.

S	M	F	Condition	S	M	F	Condition	S	M	F	Condition
☐	☐	☐	AIDS	☐	☐	☐	Diabetes	☐	☐	☐	Muscular Dystrophy
☐	☐	☐	Anemia	☐	☐	☐	Dislocated Joints	☐	☐	☐	Neck Pain
☐	☐	☐	Arthritis	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Asthma	☐	☐	☐	German Measles	☐	☐	☐	Numbness
☐	☐	☐	Back Pain	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Bladder Trouble	☐	☐	☐	Heart Trouble	☐	☐	☐	Poor Circulation
☐	☐	☐	Bone Fracture	☐	☐	☐	Hepatitis	☐	☐	☐	Reproductive Disorders
☐	☐	☐	Bowel Control Loss	☐	☐	☐	High Blood Pressure	☐	☐	☐	Rheumatic Fever
☐	☐	☐	Cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	Serious Injury
☐	☐	☐	Chest Pain	☐	☐	☐	Indigestion	☐	☐	☐	Sinus Trouble
☐	☐	☐	Concussion	☐	☐	☐	Kidney Disorder	☐	☐	☐	Tuberculosis
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Venereal Disease
				☐	☐	☐	Multiple Sclerosis				

Have you been treated by a physician for ANY health condition in the last year? ☐ Yes ☐ No

Condition Treated: ______________________ Date of Last Physical: ____________

Back →

SURGICAL HISTORY:

1. ______________________________ Date:______________
2. ______________________________ Date:______________
3. ______________________________ Date:______________

Have you ever had a metal implant? ☐ Yes ☐ No   Ever had a gunshot wound? ☐ Yes ☐ No

ACCIDENT HISTORY

☐ Job ☐ Auto ☐ Other ____________________ Date:______________
☐ Job ☐ Auto ☐ Other ____________________ Date:______________
☐ Job ☐ Auto ☐ Other ____________________ Date:______________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Please Rate Your Symptoms 1-10, 1 being least worrisome

____ __________

____ __________

____ __________

____ __________

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 MEDICATIONS? ☐ NO ☐ YES Which one(s):______________________

ARE YOU TAKING ANY MEDICATIONS? ☐ NO ☐ YES What:______________________

ARE YOU PREGNANT? ☐ NO ☐ YES   ARE YOU BREASTFEEDING? ☐ NO ☐ YES

Patient signature:______________________________ Date:__________________

Parent/Guardian signature:__________________________ Date:__________________