



CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address: _____

Please Check Type of Payment: Cash Check MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____ Your SS#: _____

Do You Have Health Insurance? Yes No Insurance Company: _____

Insurance Plan/Group#: _____ Your Work Hours: _____

Do You Have Medicare? Yes No Medicaid? Yes No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer: _____ Occupation: _____

Office Phone: _____ Cell Phone: _____ Spouse's SS#: _____

Describe The Major Complaints That Bring You To Our Office: _____

Is Your Condition Due To An Accident? Yes No Date of Accident: _____

Type of Accident? Auto Work/Job At Home Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____ Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.



HEALTH HISTORY

Name: _____ Date: _____

List All Current Health Problems: _____

List Any Other Doctors Seen, Treatments And Results Obtained: _____

Your Current Physician(s)/Therapist(s): _____

List All Surgeries And Their Dates: _____

List Any Medications You Are Taking: _____

List Any Traumas And Their Dates: _____

Please Check The Conditions You Have Or Have Had:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease | |

Please Check All Present Symptoms:

CARDIOVASCULAR

- General swelling
- Swelling in legs
- Swelling in face
- Swelling around eyes
- Chest pain
- Pounding heart beat
- Rapid heart beat
- Irregular heart beat
- Blue or purple skin
- Blue or purple nail beds
- Cold hand/feet

VERTEBROBASILAR

- Double vision
- Loss of coordination
- Loss of memory
- Ringing in ears
- Heart attack
- High blood pressure
- Muscle weakness
- Dizziness
- Blurred vision
- Stroke
- Hypertension
- Inability to form words
- Burning sensations
- Blindness
- Previous head injury
- Previous neck injury
- Taking birth control pills
- Family history of stroke
- Blood vessel disease
- Check if you smoke
- Fainting
- Area of numbness



MUSCULOSKELETAL SYSTEM

Please Check All Present Symptoms:

Head

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Dizziness
- Light headedness
- Loss of taste
- Loss of smell
- Loss of hearing
- Loss of balance

Neck

- Pain in neck
- Pain with movement
- Swelling in neck
- Stiffness in neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

Mid-Back

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms

Lower Back

- Lower back pain
- Lower back feels out of place
- Muscle spasms

Shoulders

- Pain in shoulders
- Pain across shoulders
- Muscle spasms
- Can't raise arm
- Above shoulder
- Above head

Arms & Hands

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pins & needles
- In arms
- In fingers
- Fingers go to sleep
- Cold hands
- Swollen fingers
- Loss of grip strength

Hips, Legs & Feet

- Pain in buttocks
- Pain in hip
- Pain down leg
- Knee pain
- Leg cramps
- Pins & needles in legs
- Numbness in legs
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen feet



HEALTH REVIEW

Please Check All Present Symptoms:

Skin, Hair, Nails

- Eczema
- Itchy skin
- Rough, scaly skin
- Dry skin
- Oily skin
- Yellow skin
- Bruise easily
- Baldness
- Paper thin nails
- Nail biting

Eyes

- Blurred vision
- Double vision
- Eye fatigue
- Excessive tearing
- Lack of tearing
- Light bothers eyes
- Excessive itching
- Pain in eyeball

Ears

- Loss of hearing
- Not sufficient
- Pain in ears
- Discharge from ears
- Vertigo
- Ringing in ears

Nose & Sinuses

- Nose bleeds
- Pressure over eyes
- Nose obstruction
- Frequent colds
- Sinusitis
- Loss of smell
- Allergies

Mouth & Throat

- Pain in throat
- Bleeding gums
- Abscessed teeth
- Dentures
- Difficulty swallowing

Respiratory

- Shortness of breath
- Dry cough
- Coughing up blood
- Wheezing
- Productive cough

Gastrointestinal

- Poor appetite
- Constant nibbling
- Difficulty swallowing
- Indigestion
- Nausea & vomiting
- Abdominal pain
- Change in bowel habits
- Diarrhea
- Constipation
- Hemorrhoids

Genitourinary

Urination is

- Frequent
- Not sufficient

The amount is

- High
- Moderate
- Low
- Frequent urination at night
- Intense desire to urinate
- Difficulty urinating
- Lack of control
- Pain with urination
- Dribbling
- Bloody urine
- Cloudy urine

Venereal Disease

- Syphilis
- Gonorrhea
- Other

Women Only

- painful periods
- spotting
- premenstrual symptoms
- irregular periods
- lumps in breast
- vaginal discharge
- # of pregnancies _____
- # of deliveries _____

Social History

- Smoking
- Other tobacco use
- Alcohol use
- Drink coffee or tea

Diet is

- Balanced
- Not balanced

Rest is

- Sufficient
- Not sufficient

Recreation is

- Sufficient
- Not sufficient

Family stress is

- Severe
- High
- Moderate
- Minimal
- None

My job stress is

- Severe
- Moderate
- Minimal
- None

- Nervousness
- Irritability
- Fatigue
- Depression
- Panic attacks
- Problems sleeping
- Generally feel run-down