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 ? ____
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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 ______________________
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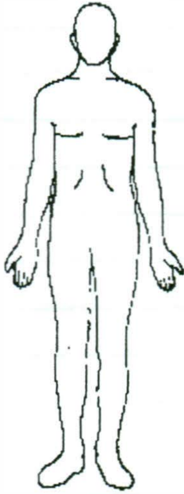
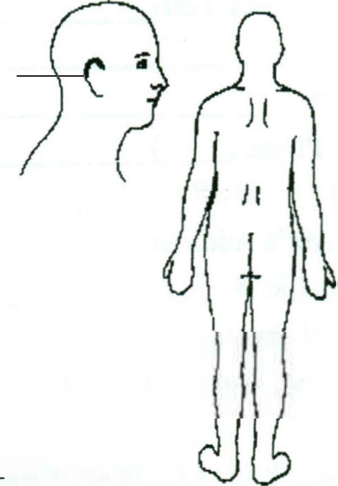
PATIENT PAIN DRAWING

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.

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Print Patient Name

____________________ ____________________

Patient signature ***Date***