CONFIDENTIAL PATIENT INFORMATION

Date:

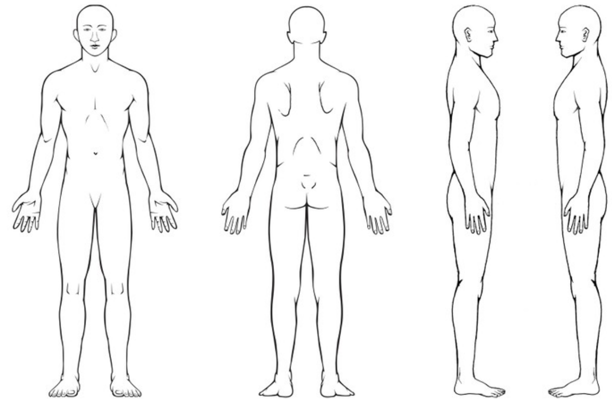
Who Referred You?				E-Mail:			
Name:							
Address:							
City:		State:		Zip:			
Cell Phone:		Alternate Phone		Age:		Birthdate:	
Social Security#(If Using Insurance):		Occupation:					
Employer City Location:							
Marital Status:				Number of Children:			
Name of Spouse:		Spouse Occupation:					
Employer:							
Emergency Contact Person:		Phone Number:					

Describe Your Condition/Complaint?			
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:	
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			

PATIENT PAINDRAWING

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: Check (✓) the symptoms you are experiencing Presently (during the last few weeks).

GENERAL	☐ Fever	☐ Frequent colds	☐ Slow heartbeat	☐ Excessive thirst/hunger
☐ Headache	☐ Chills	☐ Enlarged thyroid	☐ High blood pressure	☐ Vomiting of blood
☐ Head seems too heavy	☐ Sweats	☐ Tonsillitis	☐ Low blood pressure	☐ Pain over stomach
☐ Shoulders feel heavy	☐ Loss of Sleep	☐ Enlarged glands	☐ Pain over heart	☐ Constipation
☐ Loss of memory	☐ Allergies	**SKIN**	☐ Previous heart problems	☐ Diarrhea
☐ Equilibrium Problems	☐ Nausea	☐ Skin eruptions	☐ Hardening of arteries	☐ Hemorrhoids
☐ Dizziness	**EAR,NOSE,THROAT**	☐ Itching	☐ Swelling of ankles	☐ Liver problems
☐ Fainting	☐ Failing vision	☐ Bruise easily	☐ Poor circulation	☐ Gall bladder problems
☐ Tremors	☐ Nearsightedness	☐ Dry skin	☐ Paralytic stroke	**FOR WOMEN**
☐ Neck Pain	☐ Far sightedness	☐ Boils	**GENITOURINARY**	☐ Painful menst. periods
☐ Neck Stiffness	☐ Blurred vision	☐ Moles	☐ Frequent urination	☐ Cramps or backache
☐ Neck motion restricted	☐ Deafness	☐ Varicose veins	☐ Painful urination	☐ Irregular cycle
☐ Upper back pain	☐ Earache	☐ Sensitive skin	☐ Blood in urine	☐ Excessive Flow
☐ Low back pain	☐ Ear noises	**RESPIRATORY**	☐ Pus in urine	☐ Previous miscarriage
☐ Pins/needles in arm/legs	☐ Ear discharge	☐ Chronic cough	☐ Kidney infection/stones	☐ Vaginal discharge
☐ Arm/leg numbness	☐ Sinus infection	☐ Spitting phlegm	☐ Bed wetting	☐ Lumps in breast
☐ Loss of taste	☐ Nose bleeds	☐ Spitting blood	☐ Inability to control urine	☐ Menopausal symptoms
☐ Loss of smell	☐ Nasal obstruction	☐ Chest pain	☐ Prostate problems	☐ Hot flashes
☐ Extreme nervousness	☐ Nasal drainage	☐ Difficulty breathing	☐ Hernia	☐ Pregnant ☐ Yes ☐ No
☐ Tension	☐ Sore throat	☐ Shortness of breath	**GASTROINTEST**	☐ Breast implants
☐ Anxiety	☐ Hoarseness	**CARDIOVASCULAR**	☐ Poor appetite	
☐ Fatigue	☐ Gum disease	☐ Rapid heartbeat	☐ Poor digestion	

DISEASE PROCESSES: *Please Check 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 Check applicable items:	☐ Appendix	☐ Hernia	☐ Spine	☐ Prostate
	☐ Rectal	☐ Joints	☐ Gall Bladder	☐ Implants
	☐ Tonsils	☐ Heart	☐ Female Organs	
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?				

FINENCIAL ARRANGEMENTS					
Will You Be Using Insurance? ☐ YES ☐ NO Primary Insurance Company					
Name of Insured:		D.O.B. of Insured:		Relationship to Insured:	

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