# 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:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ E-mail:_____
Social Security#_____ Age:_____ ☐Male ☐Female
Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Other_____
Name of Spouse or Nearest Relative:_____ PH# _____
Your Occupation:_____ Employer:_____

**How Did You Hear About Us?**

☐Yellow Pages ☐Mail ☐Location ☐Radio ☐TV ☐Insurance Provider
☐Attorney_____ ☐ Friend/ Family_____
☐Previous Patient_____ ☐ Other:_____

**Payment For Services**

☐Automobile Insurance_____ ☐ Workers Comp._____
☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance_____
Health Insurance Info:
Insured's Employer:_____ Insured's SS#_____
Employer Ph#_____
Are you covered by more than one insurance company? ☐yes ☐no
If yes, who? _____

**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 | |
|---|---|---|---|
| ☐ | ☐ | ☐ | AIDS |
| ☐ | ☐ | ☐ | anemia |
| ☐ | ☐ | ☐ | arthritis |
| ☐ | ☐ | ☐ | asthma |
| ☐ | ☐ | ☐ | back pain |
| ☐ | ☐ | ☐ | bladder trouble |
| ☐ | ☐ | ☐ | bone fracture |
| ☐ | ☐ | ☐ | cancer |
| ☐ | ☐ | ☐ | chest pain |
| ☐ | ☐ | ☐ | concussion |
| ☐ | ☐ | ☐ | convulsions |
| ☐ | ☐ | ☐ | diabetes |
| ☐ | ☐ | ☐ | indigestion |
| ☐ | ☐ | ☐ | dislocated joints |
| ☐ | ☐ | ☐ | epilepsy |

| S | M | F | |
|---|---|---|---|
| ☐ | ☐ | ☐ | headaches |
| ☐ | ☐ | ☐ | heart troubles |
| ☐ | ☐ | ☐ | reproductive disorder |
| ☐ | ☐ | ☐ | high blood pressure |
| ☐ | ☐ | ☐ | HIV/ ARC |
| ☐ | ☐ | ☐ | kidney disorder |
| ☐ | ☐ | ☐ | bowel control loss |
| ☐ | ☐ | ☐ | menstrual cramps |
| ☐ | ☐ | ☐ | multiple sclerosis |
| ☐ | ☐ | ☐ | muscular dystrophy |
| ☐ | ☐ | ☐ | neck pain |
| ☐ | ☐ | ☐ | nervousness |
| ☐ | ☐ | ☐ | numbness |
| ☐ | ☐ | ☐ | polio |
| ☐ | ☐ | ☐ | poor circulation |

| S | M | F | |
|---|---|---|---|
| ☐ | ☐ | ☐ | rheumatic fever |
| ☐ | ☐ | ☐ | rheumatism |
| ☐ | ☐ | ☐ | scarlet fever |
| ☐ | ☐ | ☐ | serious injury |
| ☐ | ☐ | ☐ | sinus trouble |
| ☐ | ☐ | ☐ | tuberculosis |
| ☐ | ☐ | ☐ | venereal disease |
| ☐ | ☐ | ☐ | OTHER |

_____

☐ ☐ ☐ German measles ☐ ☐ ☐ hepatitis

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**

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

Have you ever had a metal implant? ☐ 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 1-10 with 1 being the least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

When and How Occurred?

_____

_____

Symptoms developed from: ☐ Job related ☐ Auto Accident ☐ Unknown cause

☐ Gradual Onset ☐ Other _____

Symptoms have persisted for: ___ Hours ___ Days ___ Weeks ___ Months___ Years

Symptoms/ Complaints: ☐ Come & Go ☐ Are Constant

Have you ever had this before?: ☐Yes ☐ No When?_____

What do you think is causing your complaints? _____

_____

Name and Number of Doctors previously seen for present conditions:_____

_____

Are you allergic to any medications? ☐ Yes ☐ No What?_____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period:_____

**Check things that aggravate your condition:** ☐ Bending ☐ Reaching ☐ Lifting ☐ Straining at stool ☐ Coughing ☐ Sitting ☐ Turning head ☐ Sneezing ☐ Walking ☐ Standing ☐ Lying down

**Check things that relieve your condition:** ☐ Bending ☐ Reaching ☐ Lifting ☐ Standing ☐ Lying down ☐ Turning down ☐ Sitting ☐ Walking

**Check any additional symptoms:** ☐ blurred vision ☐ buzzing in ears ☐ cold feet ☐ cold hands ☐ cold sweats ☐ concentration loss/ confusion ☐ constipation ☐ diarrhea ☐ depression /weeping spells ☐ dizziness ☐ face flushed ☐ fainting ☐ fatigue ☐ fever ☐ head seems to heavy ☐ headaches ☐ insomnia ☐ light bothers the eyes ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ low resistance to colds ☐ muscle jerking ☐ stiff neck ☐ numbness in fingers ☐ numbness in toes ☐ pins and needles in arms ☐ stomach upset ☐ pins and needles in legs ☐ ringing in ears ☐ shortness in breath ☐ Other_____

**Please list anything else you would like the doctor to know here:**

**Patient Signature:** _____ **Date:**_____