**Confidential Patient Data**

**Patient Information**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_     State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Male   🞏 Female

Marital Status:    🞏 Married 🞏 Single  🞏 Divorced 🞏 Separated   🞏 Other

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Emergency Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Your Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to this office by: Friend/Family Member - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yellow Pages     🞏 Mail Clinic Location - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this visit due to a:     🞏 Automobile Insurance 🞏 Workers Compensation   🞏 Other

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name on the Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you covered by more than one insurance company:    🞏 Yes 🞏 No - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical/Family History:     S = Self    M = Mother F = Father**

(Please indicate which conditions have been experienced by marking the appropriate boxes)

**S M F** **S M F** **S M F**

🞏 🞏 🞏 Neck discomfort 🞏 🞏 🞏 Joint pain 🞏 🞏 🞏 Fatigue

🞏 🞏 🞏 Mid back discomfort 🞏 🞏 🞏 Knee pain 🞏 🞏 🞏 Insomnia

🞏 🞏 🞏 Low back discomfort 🞏 🞏 🞏 Shoulder pain 🞏 🞏 🞏 Organ disorder

🞏 🞏 🞏 Headaches 🞏 🞏 🞏 Scoliosis 🞏 🞏 🞏 Serious injury

🞏 🞏 🞏 High blood pressure 🞏 🞏 🞏 Arthritis 🞏 🞏 🞏 Weight concerns

🞏 🞏 🞏 Asthma 🞏 🞏 🞏 High cholesterol 🞏 🞏 🞏 Heart trouble

🞏 🞏 🞏 Depression 🞏 🞏 🞏 Constipation 🞏 🞏 🞏 Bone fracture

🞏 🞏 🞏 Nervousness 🞏 🞏 🞏 Diarrhea 🞏 🞏 🞏 Fertility problems

🞏 🞏 🞏 Diabetes 🞏 🞏 🞏 Irritable bowels 🞏 🞏 🞏 Menstrual cramps

🞏 🞏 🞏 Indigestion 🞏 🞏 🞏 Allergies 🞏 🞏 🞏 Poor circulation

🞏 🞏 🞏 Sinus trouble 🞏 🞏 🞏 Stroke 🞏 🞏 🞏 Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type)

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

Describe Why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have permission to send your information to this doctor: 🞏 Yes 🞏 No

Surgical History:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a metal implant? 🞏 Yes 🞏 No

Accident History: 🞏 Job 🞏 Auto 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accident History: 🞏 Job 🞏 Auto 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accident History: 🞏 Job 🞏 Auto 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Describe Present Major Complaints:**

Please rate your symptoms (1-10, 1 being the least serious)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Symptoms are worse in: 🞏 Morning 🞏 Afternoon 🞏 Night

When and how it occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms developed from: 🞏 Job related injury 🞏 Auto accident 🞏 Other 🞏 Accident 🞏 Illness 🞏 Unknown

 🞏 Gradual Onset Date Occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms have persisted for: \_\_\_\_\_\_ Hours \_\_\_\_\_\_ Days \_\_\_\_\_\_ Weeks \_\_\_\_\_\_ Months \_\_\_\_\_\_ Years

Symptoms / Complaints: 🞏 Come and 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications: 🞏 No 🞏 Yes - What Kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications: 🞏 No 🞏 Yes What:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant: 🞏 No 🞏 Yes Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the following activities that aggravate your condition:

🞏 Bending 🞏 Reaching 🞏 Straining at stool 🞏 Coughing 🞏 Sitting 🞏 Turning Head 🞏 Lifting 🞏 Sneezing 🞏 Walking 🞏Lying Down 🞏 Standing

Please check any additional symptoms you may be experiencing:

🞏 Blurred vision 🞏 Buzzing in ears 🞏 Cold feet 🞏 Cold hands 🞏 Cold sweats

🞏 Concentration loss 🞏 Face flushed 🞏 Constipation 🞏 Depression 🞏 Diarrhea 🞏 Dizziness 🞏 Headaches 🞏 Fainting 🞏 Fatigue 🞏 Fever

🞏 Heavy head 🞏 Loss of taste 🞏 Insomnia 🞏 Light bothers eyes 🞏 Balance loss 🞏 Loss of smell 🞏 Numbness in toes 🞏 Pins and Needles 🞏 Muscle jerking 🞏 Upset stomach 🞏 Numbness in fingers 🞏 Ringing in ears 🞏 Stiff neck 🞏 Low resistance to colds

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list here any symptoms or non-optimal physical conditions you are experiencing. Please indicate any aspect of your health or your body which is not functioning at 100% of the way you think it should function. This could include muscles that get tight, pain that only occurs once in a while, symptoms that you think might not be related to your visit today, or problems which you feel are under control (but are present, even if its infrequent)**

Symptom, Condition or part of the body not functioning optimally: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often does it occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does it feel like? (Sharp, Shooting, Dull, Burning, Throbbing, Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 to 10 (10 being the worst) what does it feel like most of the time: \_\_\_\_\_\_ When its really bad: \_\_\_\_\_\_

List any treatments received for this condition and did it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medication have you taken for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Taken for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage each time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the ways it effects you at home, work, or how it effects your other activities:

Please list the goals you’d like to achieve from receiving treatment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_