CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT) DATE_____

IS YOUR VISIT DUE TO AN ACCIDENT? ❑ YES ❑ NO

PATIENT DATA:

NAME:_____ HOME PHONE: (_____) _____ WORK PHONE: (____) _____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

AGE:_____ BIRTHDATE:_____ MARITAL STATUS: M S D W NUMBER OF CHILDREN:_____

OCCUPATION:_____ EMPLOYED BY:_____

BUSINESS ADDRESS:_____

SOCIAL SECURITY #:_____

NAME OF NEAREST RELATIVE:_____ PHONE NUMBER: (_____) _____

SPOUSE NAME:_____ BIRTHDATE:_____

WORK PHONE: (_____) _____SPOUSES OCCUPATION:_____

EMPLOYED BY:_____

PRESENT COMPLAINT:

DESCRIBE YOUR PROBLEM **(REQUIRED PRIOR TO TREATMENT)**: _____

_____

_____

OTHER DOCTOR/S SEEN FOR THIS PROBLEM:_____

HOSPITALIZED? ❑ YES ❑ NO HOW MANY DAYS?_____ NUMBER OF DAYS MISSED FROM WORK?_____

MEDICAL HISTORY:

(If any of the following are relevant to your medical history, please check the accompanying box.)

❑ POLIO	❑ DIABETES	❑ RHEUMATISM	❑ SCARLET FEVER	❑ DIGESTIVE DISORDERS
❑ ANEMIA	❑ HEPATITIS	❑ CONCUSSION	❑ HEART TROUBLE	❑ HIGH BLOOD PRESSURE
❑ ASTHMA	❑ ARTHRITIS	❑ CONVULSIONS	❑ GERMAN MEASLES	❑ MUSCULAR DYSTROPHY
❑ CANCER	❑ DIZZINESS	❑ NERVOUSNESS	❑ RHEUMATIC FEVER	❑ HEADACHES
❑ NEURITIS	❑ NUMBNESS	❑ TUBERCULOSIS	❑ VENEREAL DISEASE	❑ CARPAL TUNNEL
❑ EPILEPSY	❑ BACKACHES	❑ SINUS TROUBLE	❑ MULTIPLE SCLEROSIS	❑ OTHER_____

PREVIOUS CARE:

SURGERIES:_____ WHEN?_____

TREATED BY A PHYSICIAN FOR ANY CONDITION IN THE LAST 12 MONTHS? YES ❑ NO ❑

DESCRIBE CONDITION:_____ DATE OF LAST PHYSICAL EXAM:_____

CURRENT MEDICATIONS:_____

ALLERGIC TO ANY MEDICATION? ❑ YES ❑ NO WHAT KIND?_____

PREGNANT? ❑ YES ❑ NO DATE OF LAST MENSTRUAL PERIOD:_____

HABITS		**EXERCISE**		**FAMILY HISTORY**				
					DIABETES	CANCER	BACK PAIN	OTHER
❑ SMOKING	PACKS/DAY:_____	❑ NONE						
❑ ALCOHOL	CUPS/DAY:_____	❑ MODERATE		MOTHER	❑	❑	❑	_____
❑ COFFEE	CUPS/DAY:_____	❑ DAILY		FATHER	❑	❑	❑	_____
❑ SOFT DRINK	CANS/DAY:_____	___TIMES/WEEK		BROTHER(S)	❑	❑	❑	_____
❑ WATER	CUPS/DAY:_____			SISTER(S)	❑	❑	❑	_____

INSURANCE DATA: (Clinic policy requires payment arrangements be made on the first visit.)

NAME OF PARTY RESPONSIBLE FOR PAYMENT:_____ PHONE NUMBER: (____) _____

DO YOU HAVE INSURANCE? ❑ YES ❑ NO COMPANY:_____

PATIENT'S INSURANCE:_____ EMPLOYEE I.D. NO._____

ADDRESS & PHONE:_____

SPOUSE'S INSURANCE:_____ POLICY NO._____

ADDRESS & PHONE:_____

WORKER'S COMPENSATION INS._____ GROUP NO._____

ADDRESS & PHONE_____

OTHERS:_____ MEDICARE NO._____

PATIENT AGREEMENT:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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:_____

SPOUSE'S OR GUARDIANS SIGNATURE:_____ DATE:_____

CONFIDENTIAL PATIENT INFORMATION– Cont'd

1. When did your condition start ?

_____

_____

2.What relieves your symptoms? (circle all that apply):

Sitting Standing Walking Lying Ice

Medication Stretching Massage Heat

Other:_____

_____

3. What aggravates your symptoms? (circle all that apply):

Sitting Standing Walking Bending

Twisting Lifting Driving Desk Work

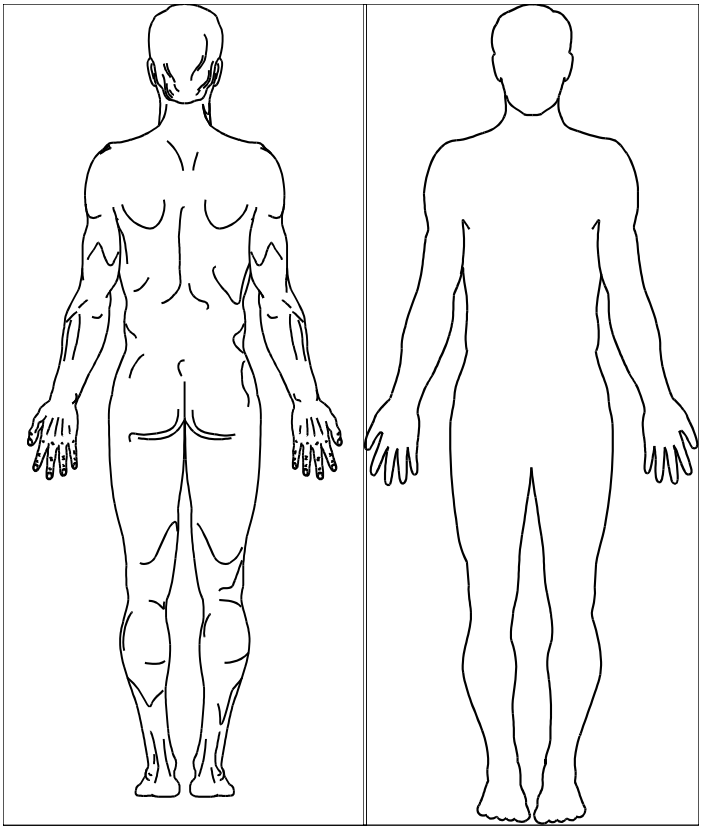
Computer Work Turning The Neck Lying

Other:_____

_____

_____

On the diagram below, mark the areas of your symptoms. Use the following symbols to indicate the characteristics of the symptoms:
Sharp Pain=X, ache=0, Numbness=N, Tingling=T, Burning=B, Weakness=W



4. What were you doing when your symptoms started? (ie. Did you bend over and lift something?) If your symptoms developed gradually, then please indicate in the space provided:_____

_____

5. When are your symptoms the most intense? (circle one): Early Morning Mid Morning Mid-day Early Afternoon Late Afternoon Evening Constant Aggravated Only By Position And Activity

6. Other doctors seen for this condition: _____

7. Is the condition staying the same, getting worse, or better?_____

8. What was done for your condition yourself? _____

9. Medication taken for this condition: _____

10. Anyone recommend surgery (Yes, No)/ Comments: _____

_____