



# CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.

If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: M S W D No. of Children \_\_\_\_\_

Referred by: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please Check Type of Payment:  Cash  Check  MasterCard/Visa

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years on Job: \_\_\_\_\_

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

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Your SS#: \_\_\_\_\_

Do You Have Health Insurance?  Yes  No Insurance Company: \_\_\_\_\_

Insurance Plan/Group#: \_\_\_\_\_ Your Work Hours: \_\_\_\_\_

Do You Have Medicare?  Yes  No Medicaid?  Yes  No

Name of Spouse or Parent: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Spouse's SS#: \_\_\_\_\_

Describe The Major Complaints That Bring You To Our Office: \_\_\_\_\_

Is Your Condition Due To An Accident?  Yes  No Date of Accident: \_\_\_\_\_

Type of Accident?  Auto  Work/Job  At Home  Other: \_\_\_\_\_

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. 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:** \_\_\_\_\_

**Guardian's Signature (For Minors):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice to our new patients:** Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.



# HEALTH HISTORY

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

List All Current Health Problems:

---

---

List Any Other Doctors Seen, Treatments And Results Obtained:

---

---

Your Current Physician(s)/Therapist(s):

---

List All Surgeries And Their Dates:

---

---

List Any Medications You Are Taking:

---

---

List Any Traumas And Their Dates:

---

---

***Please Check The Conditions You Have Or Have Had:***

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Parkinson's disease |   |

***Please Check All Present Symptoms:***

## **CARDIOVASCULAR**

- General swelling
- Swelling in legs
- Swelling in face
- Swelling around eyes
- Chest pain
- Pounding heart beat
- Rapid heart beat
- Irregular heart beat
- Blue or purple skin
- Blue or purple nail beds
- Cold hand/feet

## **VERTEBROBASILAR**

- Double vision
- Loss of coordination
- Loss of memory
- Ringing in ears
- Heart attack
- High blood pressure
- Muscle weakness
- Dizziness
- Blurred vision
- Stroke
- Hypertension
- Inability to form words
- Burning sensations
- Blindness
- Previous head injury
- Previous neck injury
- Taking birth control pills
- Family history of stroke
- Blood vessel disease
- Check if you smoke
- Fainting
- Area of numbness



---

# MUSCULOSKELETAL SYSTEM

---

*Please Check All Present Symptoms:*

## **Head**

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Dizziness
- Light headedness
- Loss of taste
- Loss of smell
- Loss of hearing
- Loss of balance

## **Neck**

- Pain in neck
- Pain with movement
- Swelling in neck
- Stiffness in neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

## **Mid-Back**

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms

## **Lower Back**

- Lower back pain
- Lower back feels out of place
- Muscle spasms

## **Shoulders**

- Pain in shoulders
- Pain across shoulders
- Muscle spasms
- Can't raise arm
- Above shoulder
- Above head

## **Arms & Hands**

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pins & needles
- In arms
- In fingers
- Fingers go to sleep
- Cold hands
- Swollen fingers
- Loss of grip strength

## **Hips, Legs & Feet**

- Pain in buttocks
- Pain in hip
- Pain down leg
- Knee pain
- Leg cramps
- Pins & needles in legs
- Numbness in legs
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen feet



# HEALTH REVIEW

**Please Check All Present Symptoms:**

## **Skin,Hair,Nails**

- Eczema
- Itchy skin
- Rough, scaly skin
- Dry skin
- Oily skin
- Yellow skin
- Bruise easily
- Baldness
- Paper thin nails
- Nail biting

## **Eyes**

- Blurred vision
- Double vision
- Eye fatigue
- Excessive tearing
- Lack of tearing
- Light bothers eyes
- Excessive itching
- Pain in eyeball

## **Ears**

- Loss of hearing
- Not sufficient
- Pain in ears
- Discharge from ears
- Vertigo
- Ringing in ears

## **Nose & Sinuses**

- Nose bleeds
- Pressure over eyes
- Nose obstruction
- Frequent colds
- Sinusitis
- Loss of smell
- Allergies

## **Mouth & Throat**

- Pain in throat
- Bleeding gums
- Abscessed teeth
- Dentures
- Difficulty swallowing

## **Respiratory**

- Shortness of breath
- Dry cough
- Coughing up blood
- Wheezing
- Productive cough

## **Gastrointestinal**

- Poor appetite
- Constant nibbling
- Difficulty swallowing
- Indigestion
- Nausea & vomiting
- Abdominal pain
- Change in bowel habits
- Diarrhea
- Constipation
- Hemorrhoids

## **Genitourinary**

- Urination is
- Frequent
  - Not sufficient
- The amount is
- High
  - Moderate
  - Low
  - Frequent urination at night
  - Intense desire to urinate
  - Difficulty urinating
  - Lack of control
  - Pain with urination
  - Dribbling
  - Bloody urine
  - Cloudy urine

## **Venereal Disease**

- Syphilis
- Gonorrhea
- Other

## **Women Only**

- painful periods
- spotting
- premenstrual symptoms
- irregular periods
- lumps in breast
- vaginal discharge
- # of pregnancies \_\_\_\_\_
- # of deliveries \_\_\_\_\_

## **Social History**

- Smoking
- Other tobacco use
- Alcohol use
- Drink coffee or tea

## **Diet is**

- Balanced
- Not balanced

## **Rest is**

- Sufficient
- Not sufficient

## **Recreation is**

- Sufficient
- Not sufficient

## **Family stress is**

- Severe
- High
- Moderate
- Minimal
- None

## **My job stress is**

- Severe
- Moderate
- Minimal
- None

- Nervousness
- Irritability
- Fatigue
- Depression
- Panic attacks
- Problems sleeping
- Generally feel run-down