CONFIDENTIAL PATIENT INFORMATION

Date_____

Name_____ Home_____ Work_____

Please check if you do not want to be contacted by email ☐

Cell_____ Email_____

Address_____ City_____ State_____ Zip_____

Age_____ Date of Birth_____ Marital Status_____ Sex_____ No. Of Children_____

Soc Sec #_____ Occupation_____ Employed By_____

Spouse's Name_____ Date of Birth_____ Soc Sec #_____

Spouse's Employer _____

Name of Nearest Relative_____ Phone #_____

Is This Condition Related To:

A. Patient's Employment Yes_____ No _____ B. Automobile Accident Yes_____ No _____

C. Other Yes_____ Explain_____

Have You Been Involved In An Automobile Accident In The Past: Year _____ Five Years_____ Over Five _____

Please Check The Boxes Which Apply To You O=OCCASIONAL F=FREQUENT C=CONSTANT

O	F	C	GENERAL SYMPTOMS
☐	☐	☐	ALLERGIES
☐	☐	☐	CONVULSIONS
☐	☐	☐	DIZZINESS
☐	☐	☐	FAINTING
☐	☐	☐	FATIGUE
☐	☐	☐	FEVER
☐	☐	☐	HEADACHE
☐	☐	☐	LOSS OF SLEEP
☐	☐	☐	NUMBNESS
☐	☐	☐	TREMORS
☐	☐	☐	SWOLLEN JOINTS

			PAIN OR NUMBNESS IN:
☐	☐	☐	SHOULDERS
☐	☐	☐	ARMS
☐	☐	☐	ELBOWS
☐	☐	☐	HANDS
☐	☐	☐	LEGS
☐	☐	☐	KNEES
☐	☐	☐	FEET
☐	☐	☐	PAINFUL TAILBONE
☐	☐	☐	POOR POSTURE

O	F	C	MUSCLE AND JOINTS
☐	☐	☐	ARTHRITIS
☐	☐	☐	BURSITIS
☐	☐	☐	TENDONITIS
☐	☐	☐	FOOT PAIN
☐	☐	☐	LOW BACK PAIN
☐	☐	☐	NECK PAIN OR STIFFNESS
☐	☐	☐	PAIN BETWEEN THE SHOULDERS
☐	☐	☐	UPPER BACK PAIN
☐	☐	☐	PAIN IN THE SIDES

CHECK THE CONDITIONS YOU HAVE HAD:

- ☐ ALCOHOLISM
- ☐ ANEMIA
- ☐ CANCER
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ GOUT
- ☐ LUMBAGO
- ☐ VENEREAL DISEASE

ARE YOU PREGNANT YES_____ NO ____

WHAT IS YOUR MAJOR COMPLAINT?_____

_____

OTHER COMPLAINTS _____

HOW LONG HAVE YOU HAD THIS CONDITION?_____

IS IT GETTING WORSE? YES_____ NO_____ CONSTANT PAIN?_____

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD?_____

WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

DESCRIBE OPERATIONS YOU HAVE HAD: _____

HAVE YOU BEEN TREATED BY A PHYSICIAN
FOR ANY HEALTH CONDITION IN THE LAST YEAR?_____

DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION?_____ WHAT KIND?_____

ARE YOU TAKING ANY MEDICATION?_____ WHAT KIND?_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.
A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

PATIENTS SIGNATURE_____ DATE_____

GUARDIAN'S SIGNATURE _____ DATE_____

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