

PATIENT INFORMATION

Date : ___/___/___ Patient File Number Assigned : ___ - ___
Name : _____
Address : _____
City : _____ State : _____ Zip : _____
Email : _____
 Employed Student Disabled
Occupation : _____
Employer/School : _____
Work Phone : (____) ____ - _____

Social Security #: _____ - _____ - _____
Home Phone # : (____) ____ - _____
Birth Date : ___/___/___ Age : ___
 Male Female Single Married Other
Number of Children : _____
 Spouse (if married) or Parent (for minors)
Name : _____
Address : _____
City _____ State : ___ Zip : _____

SYMPTOMS

Symptom #1 _____ Date symptom started? _____

Is this symptom due to: Non injury/gradual onset Automobile accident Work accident Home accident Other
Did this problem start: Suddenly or Gradually? Where specifically is the problem located ? _____

What activities are difficult to perform? sitting standing walking bending lying down twisting other
Type of pain? dull sharp burning tingling cramps stiffness swelling numbness throbbing
 aching shooting stinging Other. Does the pain radiate? yes no, If so where? _____

Rate the severity of your pain (1, mild discomfort to 10 sever pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go ? _____

What treatment have you already had for this condition? medication physical therapy other

Name of Doctor (s) that has treated you for this condition? _____

Notes _____

Symptom #2 _____ Date symptom started? _____

Is this symptom due to: Non injury/gradual onset Automobile accident Work accident Home accident Other
Did this problem start: Suddenly or Gradually? Where specifically is the problem located ? _____

What activities are difficult to perform? sitting standing walking bending lying down twisting other
Type of pain? dull sharp burning tingling cramps stiffness swelling numbness throbbing
 aching shooting stinging Other. Does the pain radiate? yes no, If so where? _____

Rate the severity of your pain (1, mild discomfort to 10 sever pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go ? _____

What treatment have you already had for this condition? medication physical therapy other

Name of Doctor (s) that has treated you for this condition? _____

Notes _____

Symptom #3 _____ Date symptom started? _____

Is this symptom due to: Non injury/gradual onset Automobile accident Work accident Home accident Other
Did this problem start: Suddenly or Gradually? Where specifically is the problem located ? _____

What activities are difficult to perform? sitting standing walking bending lying down twisting other
Type of pain? dull sharp burning tingling cramps stiffness swelling numbness throbbing
 aching shooting stinging Other. Does the pain radiate? yes no, If so where? _____

Rate the severity of your pain (1, mild discomfort to 10 sever pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go ? _____

What treatment have you already had for this condition? medication physical therapy other

Name of Doctor (s) that has treated you for this condition? _____

Notes _____

Are you experiencing? Headaches Nausea Dizziness Blurred Vision Ringing in your ears Light headedness

Dr.'s Ini. _____ Date ___/___/___

HEALTH HISTORY

Please check only those conditions that are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Prostrate Problem | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | _____ |

Social History <input type="checkbox"/> Smoking <input type="checkbox"/> Other Tobacco Use <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Recreational Drug Use

History

Prior Major Illnesses? : Yes No, If yes, describe: _____

Prior Operations? : Yes No, If yes, describe: _____

Prior Injuries? : Yes No, If yes, describe: _____

Current Medications? _____

Drug or Food Allergies? : Yes No, If yes, describe: _____

Immediate Family History of Diseases e.g. Diabetes, Cancer, Hypertension, Stroke, Heart Attack? : Yes No, If yes, describe: _____

Pregnant? Yes No Not Applicable

Are you having: Unexplained weight loss: Loss of sexual function Pain not related to movement Difficulty with urination or bowel movements Difficulty swallowing Night Pain (without movement)

Do you have any problems not discussed? : yes no, If yes, describe: _____

Name and address of nearest friend or relative not living with you

#Tel. : () _____ - _____

Name and address of nearest friend or relative not living with you

#Tel. : () _____ - _____

Authorization

I hereby accept full financial responsibility for charges and services rendered to the patient. I authorize the release of any medical or other information necessary to process a claim and request payment made to the provider of service. I understand that services are rendered and charged to the patient and not to the insurance company. This office cannot accept responsibility for collecting an insurance claim or negotiating a disputed settlement. I also agree that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party no signing this agreement.

Patient, Agent or Representative	Relationship	Witness	Date
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Dr.'s Ini. _____ Date ____/____/____