

Welcome

Patient Information

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: Male Female Age _____

Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Spouse's Birthdate _____ SS# _____

Spouse's Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home _____

Work _____ Ext. _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Home Ph. _____

Work Ph. _____ Ext. _____

Accident Information

Is this condition due to an accident?

Yes No Date _____

Type of accident :

Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer

Worker Comp. Other

Attorney Name (if applicable): _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an **X** on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

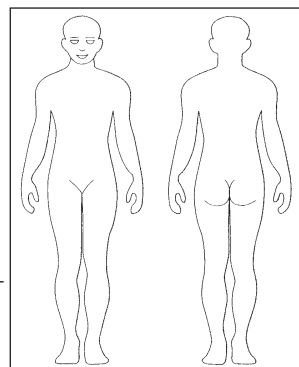
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking

Bending Lying Down



HISTORY

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name _____

Pharmacy Phone _____

GENERAL

- BREAST LUMP
- WEIGHT LOSS/GAIN
- ALLERGIES
- ANEMIA
- BLEEDING DISORDERS
- DIABETES
- CANCER/TUMORS
- THYROID DISEASE
- ALCOHOLISM
- DRUG ABUSE/CHEMICAL DEPENDENCY
- HIV

EAR, EYE, NOSE, THROAT

- POOR VISION
- DEAFNESS/DIFFICULTY HEARING
- SINUS PROBLEMS
- HOARSENESS
- TONSILLECTOMY

GASTROINTESTINAL

- POOR APPETITE/DIGESTION
- DIFFICULTY SWALLOWING
- BELCHING/GAS
- NAUSEA
- VOMITING
- ULCERS
- BLACK/BLOODY STOOLS
- LIVER PROBLEMS
- GALLBLADDER PROBLEMS
- JAUNDICE
- HERNIA
- DIARRHEA/CONSTIPATION
- APPENDICITIS
- ANOREXIA/BULIMIA

SKIN

- ITCHING
- BRUISING EASILY
- CHANGE IN MOLE
- SKIN CANCER
- SCARS (LOCATION) _____

RESPIRATORY

- CHRONIC COUGH
- SPITTING BLOOD/PHLEGM
- ASTHMA
- EMPHYSEMA
- PNEUMONIA
- TUBERCULOSIS
- BRONCHITIS

CARDIOVASCULAR

- IRREGULAR HEARTBEAT
- HIGH BLOOD PRESSURE
- HEART DISEASE
- ANKLE SWELLING
- VARICOSE VEINS
- RHEUMATIC FEVER/ARTHRITIS
- STROKE
- HIGH CHOLESTEROL
- PACEMAKER

FAMILY HISTORY

- DIABETES
- THYROID DISEASE

- TUBERCULOSIS
- KIDNEY DISEASE
- HIGH BLOOD PRESSURE
- HEART DISEASE
- CANCER
- MUSCLE, BONE OR NERVE DISEASE
- LUNG DISEASE
- ARTHRITIS
- STROKE/SEIZURES
- OTHER

HABITS

- SMOKING _____ # PACK/DAY
- DRINKING
- CAFFEINE/COFFEE

GENITOURINARY

- KIDNEY DISEASE
- FREQUENT/PAINFUL URINATION
- VENEREAL DISEASE

NEUROLOGIC

- WEAKNESS
- TWITCHING/TREMORS
- FAINTING/DIZZINESS
- HEADACHES – TYPE _____
- CONVULSION
- EPILEPSY/SEIZURES
- NUMBNESS/TINGLING
- MULTIPLE SCLEROSIS
- PINCHED NERVE
- PSYCHIATRIC CARE
- HERNIATED DISK

MUSCULOSKELETAL

- NECK STIFFNESS/PAIN
- LOW BACK PAIN
- ARTHRITIS
- OSTEOPOROSIS
- PROSTHESIS
- SCOLIOSIS
- FRACTURES

MEN

- PROSTATE PROBLEMS

WOMEN

- PAINFUL PERIODS
- IRREGULAR CYCLES
- VAGINAL INFECTIONS
- HOT FLASHES
- MISCARRIAGES
- DATE OF LAST PERIOD _____
- DATE OF LAST PAP _____

EXERCISE

- NONE
- 1-2 TIMES/WEEK
- 3-5 TIMES/WEEK
- 6-7 TIMES/WEEK
- TYPE _____

SURGERIES: _____

FALLS: _____

MEDICATIONS: _____

VITAMINS/SUPPLEMENTS: _____