



Confidential Patient Health Information

Personal Information:

Mr. Mrs. Miss Name: _____

Address: _____ City/ST: _____ ZIP: _____

Birthdate: ___/___/___ Age: _____

Marital Status: M W Sep. D Sin. Spouse Name: _____ No. of Children: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____ X _____ Other Phone () _____ - _____

Employer: _____ Occupation: _____ How Long? _____

E-mail address (for Patient newsletter): _____

HOW WERE YOU REFERRED? _____

Reason for your Visit:

Purpose of this appointment _____

Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other

Please describe the pain and its location: _____

Date of accident/injury, or when condition began: _____/_____/_____

Is condition getting worse? Yes No Staying the Same Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other

Have you been treated by another doctor for this condition? Yes No

If yes, please name doctor/health care facility: _____

Is there any chance that you are pregnant? Yes No Estimated due date: _____



Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

- | | | | |
|----------------------------------------------|---------------------------|-------------------------------------|-------------------------|
| <u>General</u> | <u>Muscle & Joint</u> | <u>Eyes, Ears Nose & Throat</u> | <u>Gastrointestinal</u> |
| C P Allergy | C P Arthritis | C P Hearing Loss | C P Colon Problems |
| C P Convulsions | C P Bursitis | C P Ear-ache | C P Constipation |
| C P Fatigue | C P Low Back Pain | C P Failing Vision | C P Diarrhea |
| C P Fainting | C P Neck Pain/Stiffness | C P Nosebleeds | C P Gall Bladder |
| C P Headache | C P Shoulder Pain | C P Sinus Infections | C P Hemorrhoids |
| C P Sudden Weight Loss | C P Spinal Curvature | C P Strep Throat | C P Hernia |
| C P High Blood Pressure | C P Midback Pain | C P Thyroid Problems | C P Liver Problems |
|
 | | | |
| <u>Vascular</u> | <u>Pain or Numbness</u> | <u>Skin Problems</u> | <u>Respiratory</u> |
| C P Nausea/Vomiting | C P Shoulders/Arms | C P Bruise Easily | C P Asthma |
| C P Dizziness | C P Elbows/Hands | C P Hives or Allergic Reaction | C P Chest Pain |
| C P Numbness on one side of the face or body | C P Hips/Legs | C P Skin Rash | C P Chronic Cough |
| C P Difficulty Swallowing | C P Ankles/Knees/Feet | C P Acne | C P Spitting up Blood |
| C P Difficulty Walking | <u>Genito-Urinary</u> | <u>For Women Only</u> | <u>Other</u> |
| C P Difficulty Speaking | C P Bedwetting | C P Cramps or Backache w/cycle | C P Stroke |
| C P Fainting/Light Headed | C P Frequent Urination | C P Excessive Menstrual Flow | C P Rheum.Fever |
| C P Double Vision | C P Kidney Infection | C P Irregular Cycles | C HIV/AIDS |
| C P Rapid Eye Movement | C P Painful Urination | C P Lumps in Breast | C P Alcoholism |
| C P Neck or Head Pain | C P Prostate Trouble | C P Pelvic Inflammatory Disease | C P Diabetes |
| | C P Kidney Stones | | C P Cancer |

Please list any medications you are taking, (including OTC) _____

Please list any medications that you are allergic to: _____

Please list all surgeries and dates _____

Medical Physician's name _____

Your Family History (some health problems are the result of familial tendencies)

Illnesses

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Social History

Do you smoke? Yes No If yes, how many packs per day? _____ For how long? _____

Do you consume alcoholic beverages? Yes No If yes, socially? Moderately? Daily? Rarely?

Do you exercise regularly? Yes No If yes, daily? 3x/week 1x/week Other (specify): _____

In the event of an emergency...

Who should we contact? _____ Relationship: _____

Home Phone #: () _____ - _____ Work Phone #: () _____ - _____ X _____