Confidential Patient Health Information

Personal Information:

☐ Mr. ☐ Mrs. ☐ Miss Name: ______________________________

Address: ____________________ City/ST: ____________________ ZIP: ________

Birthdate: ____________________ Age: _______

Marital Status: ____________________ Spouse Name: ____________________ No. of Children: ______

Home Phone: ____________________ Work Phone: ____________________ 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 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 (select "C" if the problem is a current one and "P" if you've had the problem in the past)

General
- C P Allergy
- C P Convulsions
- C P Fatigue
- C P Fainting
- C P Headache
- C P Sudden Weight Loss
- C P High Blood Pressure

Muscle & Joint
- C P Arthritis
- C P Bursitis
- C P Low Back Pain
- C P Neck Pain/Stiffness
- C P Shoulder Pain
- C P Spinal Curvature
- C P Midback Pain

Eyes, Ears Nose & Throat
- C P Hearing Loss
- C P Ear-ache
- C P Failing Vision
- C P Nosebleeds
- C P Sinus Infections
- C P Strep Throat
- C P Thyroid Problems

Gastrointestinal
- C P Colon Problems
- C P Constipation
- C P Diarrhea
- C P Gall Bladder
- C P Hemorrhoids
- C P Hernia
- C P Liver Problems

Vascular
- C P Nausea/Vomiting
- C P Dizziness
- C P Numbness on one side of the face or body
- C P Difficulty Swallowing
- C P Difficulty Walking
- C P Difficulty Speaking
- C P Fainting/Light Headed
- C P Double Vision
- C P Rapid Eye Movement
- C P Neck or Head Pain

Pain or Numbness
- C P Shoulders/Arms
- C P Elbows/Hands
- C P Hips/Legs
- C P Ankles/Knees/Feet

Skin Problems
- C P Bruise Easily
- C P Hives or Allergic Reaction
- C P Skin Rash
- C P Acne

Respiratory
- C P Asthma
- C P Chest Pain
- C P Chronic Cough
- C P Spitting up Blood

Genito-Urinary
- C P Bedwetting
- C P Frequent Urination
- C P Kidney Infection
- C P Painful Urination
- C P Prostate Trouble
- C P Kidney Stones

For Women Only
- C P Cramps or Backache w/cycle
- C P Excessive Menstral Flow
- C P Irregular Cycles
- C P Lumps in Breast
- C P Pelvic Inflammatory Disease

Other
- C P Stroke
- C P Rheum.Fever
- C HIV/AIDS
- C P Alcoholism
- C P Diabetes
- 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 may packs per day? _______ For how long?_________
Do you consume alcoholic beverages? ☐Yes ☐No If yes, how often?__________________
Do you exercise regularly? ☐Yes ☐No If yes, how often? ______________________

In the event of an emergency…

Who should we contact? ______________________ Relationship: ____________________

Home Phone #:______________________ Work Phone #:____________________

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