Date: _____

CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Name _____ Home Phone _____Cell Phone _____

Address _____ City _____State _____ Zip _____

Email Address _____

Who may we contact in case of emergency?_____ Ph # _____

Age _____ Birth date _____ Marital Status: S M W D No. of children _____

Your employer _____ Occupation _____Years on job _____

Employer Address _____ City _____ State _____Zip _____

Office Phone _____Your SS#__ _____ Driver License # _____

Do you have health insurance? YES _____ NO_____ Plan/Group _____

Insurance Company _____

Do you have other health insurance? YES _____ NO _____

Insurance company and Group # _____

Name of Spouse or Parent _____Birth date _____

Employer_____Address_____

City _____ State _____ Zip _____ Office phone_____

Spouse SS# _____ Driver License#_____

Please circle one payment type: Cash Check Mastercard/Visa

Describe the Major Complaints that bring you to our office _____

_____

Who referred you to our office? _____

Is your condition due to an accident? YES _____ NO_____ Date of Accident_____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you been in an Auto Accident? Past year _____ Past 5 years _____Over 5 years _____ Never _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse or Guardian's Signature _____ Date _____

Notice to our new patients: Full payment of services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance the deductible must be met in the beginning unless prior arrangements are made.

Name: _____ Date: _____

Health Questionnaire

List all of your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever had an industrial injury or other injury for which you received treatment? When?

Please check the conditions you have or have had:

( ) AIDS or HIV	( ) Epilepsy	( ) Polio
( ) Anemia	( ) Hypoglycemia	( ) Rheumatic Fever
( ) Arthritis	( ) Multiple Sclerosis	( ) Tuberculosis
( ) Cancer	( ) Parkinson's Disease	( ) Venereal Disease

Family History

Relation	Age	Health Problem or Cause of Death
Mother:		
Father:		
Mother's mother:		
Mother's father:		
Father's mother:		
Father's father:		
Brothers:		
Sisters:		
Children:		

Please check (X) all present symptoms.

Cardiovascular
( ) general swelling
( ) swelling in legs
( ) swelling in face
( ) swelling around eyes
( ) chest pain
( ) pounding heart beat
( ) heart "jumps"
( ) rapid heart beat
( ) blue or purple skin
( ) blue or purple nailbeds
( ) fainting
( ) hypertension

Vertebrobasilar
( ) double vision
( ) loss of coordination
( ) irregular muscle movement
( ) ringing in ears
( ) heat attack
( ) high blood pressure
( ) irregular heartbeat
( ) hardening of the arteries
( ) areas of muscle weakness
( ) dizziness with nausea
( ) dizziness without nausea
( ) blurred vision
( ) fainting spells
( ) stroke
( ) diabetes
( ) pain over the heart
( ) cold hands and/or feet
( ) areas of numbness
( ) arthritis of the neck
( ) previous neck or head injury
( ) loss of memory
( ) inability to form words (talk plainly)
( ) periods of blindness in one eye
( ) areas of abnormal sensations such as burning, etc.
( ) areas of numbness
( ) blood vessel disease (phiebitis, etc.)
( ) check if you smoke
( ) check if any of your family members have had a stroke
( ) check if you are taking birth control pills

Musculoskeletal System

Head
( ) unusually frequent headaches
( ) unusually severe headaches
( ) head feels heavy
( ) vertigo
( ) light-headedness
( ) loss of smell
( ) loss of taste
( ) loss of balance
( ) dizziness

Neck
( ) pain in neck
( ) neck pain with movement
( ) swelling in neck
( ) stiff neck
( ) pinched nerve in back
( ) neck feels out of place
( ) muscle spasms in neck
( ) grinding sounds in neck
( ) popping sounds in neck
( ) limited neck movement

Shoulders
( ) pain in shoulders (R-L)
( ) pain across shoulders
( ) tension in shoulders
( ) muscle spasms in shoulders
( ) can't raise arm
    ( ) above shoulder level
    ( ) over head

Arms & Hands
( ) pain in upper arm
( ) pain in forearm
( ) pain in hands
( ) pain in fingers
( ) sensation of pins & needles
    ( ) in arms
    ( ) in fingers
( ) fingers go to sleep
( ) hands cold
( ) swollen joints in fingers
( ) sore joints in fingers
( ) loss of grip strength

Mid-Back
( ) mid-back pain
( ) pain between shoulder blades
( ) sharp stabbing pain
( ) dull ache
( ) pain from front to back
( ) pain over kidney area
( ) muscle spasms in mid-back

Low Back
( ) low back pain
( ) low back feels out of place
( ) muscle spasms in low back

Hips, Legs, & Feet
( ) pain in buttocks
( ) pain down leg
( ) knee pain
( ) leg cramps
( ) pins & needles in legs
( ) numbness in leg
( ) numbness in toes
( ) cold feet
( ) swollen ankles
( ) swollen feet

Health Review

Skin, Hair, Nails
( ) eczema
( ) itchy skin
( ) dry scalp
( ) oily scalp
( ) rough, scaly skin
( ) dry skin
( ) oily skin
( ) psoriasis
( ) yellow skin
( ) bruise easily
( ) paper thin nails
( ) pale skin
( ) nail biting
( ) baldness

Eyes
( ) blurring of vision
( ) double vision
( ) eyes fatigue easily
( ) excessive tearing
( ) lack of tearing
( ) light bothers eyes
( ) excessive itching
( ) pain in eyeball

Ears
( ) loss of hearing
( ) pain in ears
( ) discharge from ears
( ) vertigo
( ) ringing in ears

Nose Nasopharynx Sinuses
( ) unusual nasal discharge
( ) nose bleeds
( ) pressure over eyes
( ) pressure under eyes
( ) obstruction of nose
( ) frequent colds
( ) sinusitis
( ) nasal allergies
( ) loss of sense of smell
( ) any trauma to nose

Mouth and Throat
( ) pain in mouth
( ) pain in throat
( ) bleeding gums
( ) cavities
( ) abscessed teeth
( ) dentures
( ) difficulty swallowing
( ) changes in voice

Respiratory
( ) shortness of breath
( ) can't breath while lying down
( ) can't sleep while lying down
( ) dry cough
( ) productive cough
( ) coughing up blood
( ) wheezing

Gastrointestinal
( ) poor appetite
( ) constant nibbling
( ) difficulty swallowing
( ) indigestion
( ) can't eat some foods
( ) nausea & vomiting
( ) jaundice
( ) abdominal pain
( ) change in bowel habits
( ) diarrhea
( ) constipation
( ) hemorrhoids

Genitourinary
Urination is ( ) frequent
( ) normal
( ) infrequent
The amount is ( ) high
( ) normal
( ) low
( ) need to get up at night to urinate
( ) abnormal intense desire to urinate
( ) difficulty starting urination
( ) decreased output
( ) pain on urination
( ) dribbling
( ) blood in urine
( ) cloudy urine
( ) lack of bladder control
( ) abdominal pain

Venereal Disease
( ) AIDS
( ) syphilis
( ) gonorrhea
( ) other

Social History
( ) smoking
( ) other tobacco use
( ) alcohol use
( ) drink coffee or tea

My diet is…
( ) balanced
( ) unbalanced

My rest is…
( ) sufficient
( ) not sufficient

My level of recreation is…
( ) sufficient
( ) not sufficient

My family stress is…
( ) severe
( ) moderate
( ) minimal
( ) none

How do you like your work?
( ) I like it very much.
( ) It's ok.
( ) I hate it.

My job stress is…
( ) severe
( ) moderate
( ) minimal
( ) none

( ) nervousness
( ) irritability
( ) fatigue
( ) depression
( ) generally feel run-down
( ) crave sweets
( ) crave salt

Women Only
( ) painful period
( ) spotting
( ) vaginal discharge
( ) premenstrual symptoms
( ) irregular periods
( ) lumps in breast

pregnancies _____
of deliveries _____