PATIENT INFORMATION

We apologize for the length of the paper work. It is important for the doctor to get to know you. Please fill in this information to the best of your knowledge

Date: _____

Name: _____ Nickname: _____

Home phone: _____ Cell phone: _____

Address: _____ City: _____State: _____ Zip: _____

E-mail address: _____

Age: _____ Birthdate: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Job duties:_____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names & Ages of Children: _____

_____

Name of nearest relative: _____ phone: _____

How were you referred to our office? _____

Family Medical Doctor? _____ When doctors work together, it benefits you. May we have permission to update your medical doctor regarding your care at this office? ____

HISTORY OF PRESENT ILLNESS:

Purpose of this appointment: _____

Date symptoms started or accident happened: _____

Is this due to: Auto_____ Work _____ Other_____

Have you ever had the same or similar condition? ___ Yes ___ No. If yes, when and describe: ____

_____

Have you missed days from work due to this condition ___ Yes ___ No. If yes, how many?

_____

Since the symptoms started, has it been getting (circle the best answer): Better Worse Same

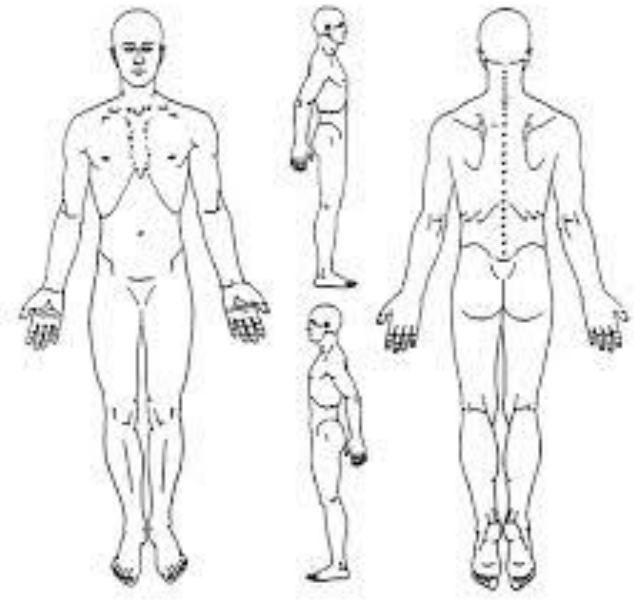
What are 3 things you are currently unable to do which you would like to be able to do? _____

_____

How would you describe your symptoms? _____

Patient Name: _____

Place an "X" on the drawings wherever you have pain



Circle the number that best describes your pain/ symptoms

0 = no pain/symptoms excruciating pain/ symptoms =10

Right now:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
On Average:	0	1	2	3	4	5	6	7	8	9	10

HEALTH HISTORY:

Do you have a history of stroke or hypertension? _____

Have you had any major illness, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ___ Yes ____ No

If yes, describe: _____

Date of last physical examination: _____ Date of last dental exam: _____

Are you taking any medications or drugs? ___ Yes ___ No If yes, please list which medications or drugs you are taking;

_____

Women only: Are you pregnant? _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?"

Yes	No	?	
___	___	___	Do you have any allergies of any kind?
___	___	___	Do you have a past history of cancer?
___	___	___	Have you had any unexplained weight loss?
___	___	___	Does your pain improve with rest?
___	___	___	Have you had spinal pain greater than 4 weeks?

Patient Name: _____

___ ___ ___ Have you had prolonged use of corticosteroids?
___ ___ ___ Any history of intravenous drug use?
___ ___ ___ Current or recent urinary tract, respiratory tract of other infections?
___ ___ ___ Immunosuppression medication &/or conditions?
___ ___ ___ History of significant trauma?
___ ___ ___ History of minor trauma?
___ ___ ___ Sudden onset of urinary retention or overflow incontinence (wet underwear)?
___ ___ ___ Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
___ ___ ___ Numbness in the groin region?

Please check the appropriate response to the following items:

Often	Sometimes	Never	
_____	_____	_____	Vigorous Exercise
_____	_____	_____	Moderate Exercise
_____	_____	_____	Alcohol Use
_____	_____	_____	Drug Use
_____	_____	_____	Tobacco Use
_____	_____	_____	Caffeine
_____	_____	_____	High Stress Activity
_____	_____	_____	Family Pressures
_____	_____	_____	Financial Pressures
_____	_____	_____	Other Mental Stresses

Do you take any supplements or vitamins?
Yes/ No. If yes, please list: _____
_____

How would you rate your overall diet?
Excellent Good Fair Poor

How would you rate your overall health?
Excellent Good Fair Poor

Have you had or do you now have any of the following symptoms/ condition. Please indicate with the letter *N* if you have these conditions *NOW* or *P* if you had these conditions *PREVIOUSLY.*
In the second line, indicate if you have a family member with a history of the symptoms/ condition. Please specify which family member: father, mother, spouse, sibling, child

	N/P	Family		N/P	Family
Headaches	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleep Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Feet Cold	_____	_____
Nervousness	_____	_____	Hands Cold	_____	_____
Tension	_____	_____	Arthritis	_____	_____
Irritability	_____	_____	Muscle Spasms	_____	_____
Chest pain	_____	_____	Frequent Colds	_____	_____
Dizziness	_____	_____	Fever	_____	_____
Shoulder/Arm Pain	_____	_____	Sinus Problems	_____	_____
Numb fingers	_____	_____	Diabetes	_____	_____
Numb toes	_____	_____	Indigestion Problem	_____	_____
High Blood Pressure	_____	_____	Menstrual Difficulties	_____	_____
Weak arms or legs	_____	_____	Joint Swelling	_____	_____
Difficulty Urinating	_____	_____	Weight Gain	_____	_____
Fatigue	_____	_____	Depression	_____	_____

Patient Name: _____

Ears Ring	_____	_____	Loss of Memory	_____	_____
Broken Bones	_____	_____	Circulation Problems	_____	_____
Migraines	_____	_____	Seizures/ Epilepsy	_____	_____
Pacemaker	_____	_____	Low Blood Pressure	_____	_____
Stroke	_____	_____	Heart Disease	_____	_____
Eating Disorder	_____	_____	Cancer	_____	_____
Drug Addiction	_____	_____	Coughing Blood	_____	_____
Gall Bladder Issues	_____	_____	Emphysema	_____	_____
Kidney Problems	_____	_____	Asthma	_____	_____
Liver Problems	_____	_____	Ulcers	_____	_____
Alcoholism	_____	_____	Constipation	_____	_____
Nerve Pain	_____	_____	Stomach pains/ problems	_____	_____
Pinched Nerve	_____	_____	Disc Problems	_____	_____
Osteoporosis	_____	_____	Scoliosis	_____	_____
Thyroid Problems	_____	_____	Other: _____		

If any of your immediate family members are deceased, please list their age at death and cause:

_____

The following person(s) have my permission to receive my personal health information:

_____

I certify the information provided is accurate to the best of my knowledge:

Signature: _____

Date: _____