

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Beginning April 2016, there will be an after-hours charge for visits that exceed regular business hours.

PATIENT INFORMATION

Patient Account # _____ Today's Date: _____

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____
 Zip: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Email Address: _____

PLEASE CHOOSE REMINDER TYPE: E-MAIL OR TEXT MESSAGE:

Reminder Type: (Only choose one) Email Text I don't want a reminder
 If you chose a text reminder who is your mobile provider? _____

Social Security #: _____ Age: _____ Male Female
 Marital Status: Married Single Divorced Separated Other _____
 Name of Spouse/Emergency Contact: _____ Phone: _____
 Your Occupation _____
 Employer: _____

HOW DID YOU HEAR ABOUT US? Family/friend Google Ad Radio Ad Social Media
 Dr. Referral Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance

Name of Insurance Co.: _____ PolicyHolder: _____
 Policy Holder's DOB: _____ ID Card #: _____
 Policy Holder's Employer: _____ Employer's Phone #: _____
 Are you covered by more than one insurance company? Yes No Name _____

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Primary Care Doctor: _____ Phone #: _____

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

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY: 1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

****Please rate each symptom from 1-10, 10 being the most severe****

1. _____
2. _____
3. _____
4. _____
5. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: ACCIDENT ILLNESS GRADUAL ONSET UNKNOWN CAUSE
 OTHER DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN?

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR THIS CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND?

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE YOUR CONDITION:**

BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING THAT **RELIEVE** YOUR CONDITION:

BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD MEDICINE WALKING

PLEASE LIST ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

Patient's Signature: _____ Date: _____