Confidential Health Information

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone #: _____ Cell Phone #: _____

Age: _____ Date of Birth: _____ S.S.#: _____ Email:_____

Marital Status (Please circle) Married Single Divorced Widowed Driver's License #: _____

Occupation: _____ Employed by:_____

Work Phone: _____ Address:_____

Is your visit due to an accident? (Please circle) YES NO If yes, please notify receptionist.

Are you a **Medicare** patient? YES NO Medicare #: _____

Spouses Name: _____ Spouses Employer: _____ Work #: _____

Name of person to contact in case of emergency: _____ Phone #: _____

Who referred you to our office so we may thank them?_____

Referring Physician: _____

Are you pregnant? YES NO Date of Last Menstrual Period? _____ Do you smoke? YES NO ____/day

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____

Signature of Parent or Guardian: _____

Insurance Coverage Information: Please fill out the information that applies:

Medical Insurance: _____ Primary Dr.: _____

Do you need a referral? _____ Policy #: _____ Group #: _____

Personal Injury/Auto Accident: (Name of Insurance Carrier):_____

Phone #: _____ Claim #: _____ Adjuster: _____

Reason for Visit:

Chief Complaint: _____ Onset Date: _____

Secondary Complaints: _____ Onset Date: _____

Other: _____

_____

_____

Present Complaints (please circle the appropriate ones)

Headache	Feet/Hands cold	Head Seems Heavy	Pins & Needles in Arms:	Right / Left
Mental Dullness	Depression	Confusion	Pins & Needles in Hands:	Right / Left
Loss of Memory	Constipation	Unbalanced	Pins & Needles in Legs:	Right / Left
Dizzy	Rib Pain	Chest Pain	Mid-Back Stiffness	
Fainting	Shortness of Breath	Ears Ringing	Double Vision	
Upper Back Pain	Neck Pain	Neck Restriction	Upper Back Stiffness	
Lower Back Pain	Fear/Nervousness	Eye Strain/Pain	Lower Back Stiffness	
Loss of Taste	Loss of Smell	Irritability	Tension	

Functional Complaints: (explain) _____

Difficulty in:	Standing	Sitting	Bending	Walking		
Pain Radiation to the:	Right Arm	Left Arm	Right Leg	Left Leg		
Cannot Lift:	5 pounds	10 pounds	20 pounds	50 pounds	Repetitive	
Pain Radiates to:	Top of Head	Neck	Base of Skull	Ribs	Shoulders	Arms

At home I have difficulty with the following activities: _____

At work I have difficulty with the following tasks: _____

What have you tried that has not helped your condition? _____

What have you tried that has helped your condition? _____

Has your problem interrupted your sleep? If yes, how much? _____

Anyone in your family with a similar condition? Yes No Explain: _____

Have you seen other doctors for this complaint? Yes No If so, who? _____

Current Medical History (List any conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystrophy	Asthma	Fibromyalgia
Neck Pain/Spasms	Anemia	Hand or Wrist Pain	Neuritis	Back Pain
Headache	Numbness	Cancer/Type _____	Heart Problems	Polio
Concussion	Hepatitis	Rheumatic Fever	High Blood Pressure	Convulsion
Sinus Trouble	Diabetes	HIV	Sciatica	Measles
Digestion Problems	TB	Dizzinezz	Multiple Sclerosis	Venereal Disease

Current Medications: (Please list the medication and reason for taking)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any surgeries with approximate dates

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