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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

Today's Date:

Name: Email Address:

Address: City: State: Zip:

Age: Birthdate: Marital Status: S M W D # of Children:

Home Phone: Cell Phone: Work Phone:

Please circle one payment type: Cash Check Mastercard/Visa Discover

Your Employer: Occupation: Years on Job:

Employer Address: City: State: Zip:

Your SS# Drivers License #

Do you have health insurance where you work? Yes No Plan/Group #

Insurance Company:

Name of Spouse or Parent: Birthdate:

Spouse Employed by: Occupation: Years on Job:

Employer Address: City: State: Zip:

Office Phone: Spouse SS# Driver License #

Does your spouse have health insurance at work? Yes No Plan/Group #

Describe the major medical complaint that brings you to our office:

Is your condition due to an accident? Yes No If yes, then date of accident:

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

Have you ever been in an auto accident? Past Year Past 5 Years Over 5 Years ago 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 no 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.

Patients Signature: Date:

Spouse or Guardian's Signature: Date:

Notice to our new patients: Full payment for 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 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? Yes No When?

Have you ever had an industrial injury or any other injury for which you received treatment? Yes No When?

Please check the conditions you have or have had:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Venereal Disease |

FAMILY HISTORY

Age

Health problems or cause of death

Mother:

Father:

Mother's mother:

Mother's father:

Father's mother:

Father's father:

Brothers:

Sisters:

Children:

Please check all present symptoms

Name

Date

CARDIOVASCULAR SYSTEM

- | | | |
|---|---|---|
| <input type="checkbox"/> general swelling | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> inability to form words (talk plainly) |
| <input type="checkbox"/> swelling in legs | <input type="checkbox"/> heart attack | <input type="checkbox"/> periods of blindness in one eye |
| <input type="checkbox"/> swelling in face | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> areas of abnormal sensations such as burning etc |
| <input type="checkbox"/> swelling around eyes | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> areas of numbness |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> hardening of the arteries | <input type="checkbox"/> blood vessel disease (phlebitis etc) |
| <input type="checkbox"/> pounding heart beat | <input type="checkbox"/> areas of muscle weakness | <input type="checkbox"/> check if you smoke |
| <input type="checkbox"/> heart "jumps" | <input type="checkbox"/> dizziness with nausea | <input type="checkbox"/> check if any of your family has had a stroke |
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> dizziness without nausea | <input type="checkbox"/> check if you are taking birth control pills |
| <input type="checkbox"/> blue or purple nail beds | <input type="checkbox"/> blurred vision | |
| | <input type="checkbox"/> fainting spells | |
| | <input type="checkbox"/> stroke | |
| | <input type="checkbox"/> diabetes | |
| | <input type="checkbox"/> pain over the heart | |
| | <input type="checkbox"/> cold hands and or feet | |
| | <input type="checkbox"/> arthritis of the neck | |
| | <input type="checkbox"/> previous neck or head injury | |
| | <input type="checkbox"/> loss of memory | |

VERTEBROBASILAR

- | | |
|--|---|
| <input type="checkbox"/> double vision | <input type="checkbox"/> arthritis of the neck |
| <input type="checkbox"/> loss of coordination | <input type="checkbox"/> previous neck or head injury |
| <input type="checkbox"/> irregular muscle movement | <input type="checkbox"/> loss of memory |

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
- stiff neck
- pinched nerve in neck
- neck feels out of place
- muscle spasms in neck
- grinding sound in neck
- popping sound in neck
- limited neck movement

SHOULDERS

- pain in shoulders (R L)
- pain across shoulders

- muscle spasms in shoulder
- can't raise arm
 - above shoulder level
 - over head

ARMS AND 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 background

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

Please check all present symptoms

Name

Date

SKIN HAIR NAILS

- eczema
- itchy skin
- dry scalp
- oily scalp
- rough, scaly skin
- dry skin
- oily skin
- psoriasis
- yellow skin
- bruises easily
- paper thin nails
- 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/ 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 & THROAT

- pain in mouth
- cavities

- dentures
- difficulty swallowing
- changes in voice

RESPIRATORY

- shortness of breath
- can't breathe while lying down
- dry cough
- productive cough
- coughing up blood
- wheezing

GASTROINTESTINAL

- poor appetite
- constant nibbling
- difficulty in 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 and urinate
- abnormal intense urge to urinate
- difficulty starting to urinate
- decreased output
- pain on urination
- dribbling
- blood in urine
- cloudy urine
- lack of bladder control
- abdominal pain
- pain in throat
- bleeding gums
- abscessed teeth

SOCIAL HISTORY

- smoking
- other tobacco use
- alcohol use
- drink coffee or tea
- diet is balanced
- unbalanced
- rest is sufficient
- insufficient
- recreation is sufficient
- insufficient
- my family stress is severe
- moderate
- minimal
- none

how do you like your work?

- I like it very much
- its ok
- I hate it

- my job stress is severe
- moderate
- minimal
- none

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

VENEREAL DISEASE

- AIDS
- syphilis
- gonorrhea
- other

WOMEN ONLY

- painful period # of pregnancies _____
- spotting
- vaginal discharge
- premenstrual symptoms # of deliveries _____
- irregular periods
- lumps in breasts