



### 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       |   |

**VERTEBROBASILAR**

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



11001 Broad St. SW, Pataskala OH 43062  
James L. Wion D.C.

P: (740) 927-3494  
F: (740) 927-3496

### Accidental Injury Report

Name:  Today's Date:

Date of Accident:  Time of Accident:  Location of Accident:

Type of Accident:  Auto/ Traffic  Work/ On the Job  At Home  Other

describe how the accident occurred in your own words

Immediately following the accident how did you feel?

How did you feel the next day?

Were you unconscious?  Yes  No In a daze?  Yes  No Did you go to the hospital?  Yes  No

If you went to the hospital, when?  At time of accident  Next day  Other

How did you get to the hospital?  Ambulance  Private Transportation

Did the ambulance attendants place you in  Neck collar  Splints  Brace  None of the above

Name of the hospital  attended by Dr.

Were you x-rayed at the hospital?  Yes  No If so, what was the diagnosis?

How long did you stay?  What treatments were rendered?

What recommendations were made?

List any other doctors you have seen as a result of this accident and what you saw them for

Have you lost any time from work because of this accident?  Yes  No If yes, give the dates

Totally disabled from  to  Partially disabled from  to

Have you returned to work since the accident?  Yes  No Please complete the below

| Date                 | Employer             | Occupation           | Light duty/ Reg. Duty | Full time/ Part time |
|----------------------|----------------------|----------------------|-----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>  | <input type="text"/> |

Since the accident occurred, are your symptoms  Improving  Getting Worse  No Change

Do you notice any activity restrictions as a result of this injury?  Yes  No Please describe:

Have you been contacted by an insurance adjuster or company representative about this accident?  Yes  No

If so, please list name and phone # of the person contacting you:

Have you retained an attorney?  Yes  No Date attorney retained or to be retained:

Attorney's name:  Phone number:

Address:

Were there any witnesses?  Yes  No Names:

Other patient information

Patient's Signature:  Date:



### Accidental Injury Report

Name:

Today's Date:

#### WORK/ ON JOB ACCIDENT

List any equipment, machinery, and/or other object related to the accident?

Was accident reported to a supervisor or employee?  Yes  No If so, whom?

Has a Worker's Compensation claim been filed?  Yes  No Insurance Carrier

Name of your immediate supervisor/ foreman:  Office phone #

Type of work being done at time of injury?

Length of time you have worked there prior to the accident?  Have you been injured before?  Yes  No

Job title / Activity:

In a typical 8 hour workday I (tick the # of hours for each activity)

Sit: 1 2 3 4 5 6 7 8 Stand: 1 2 3 4 5 6 7 8 Walk 1 2 3 4 5 6 7 8

| On the job I perform: | Not at all               | Occasionally             | Frequently               | Continuously             |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bend/ Stoop           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squat                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawl                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above head      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneel                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Push/ Pull            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I LIFT UP TO:         |                          |                          |                          |                          |
| 10 pounds             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 pounds             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 50 pounds             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature:

Date: