Confidential Patient Information

Please Let Us Know Who Referred You!____

Name:____ Home Phone:____________________________________

Address:__________________________________Apt #_______City:______________State:______Zip:_________

Email:____DOB:______________Age:_____Sex: M_____F_____

Social Security No:_____________________________Drivers License No:_____________________________

Marital Status: M_____S____W____D_____Spouse's Name_____________________________#Children______

Patient's Occupation:_________________________________Business Phone:____________________________

Business/Employer Name:____

Address:______________________________________City:_______________State:________Zip:____________

Family physician:_______________________________Phone:____

☐ I hereby give permission to release information related to my care to my family physician.

In case of an emergency please notify:_________________________Phone:_____________________________

IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING:

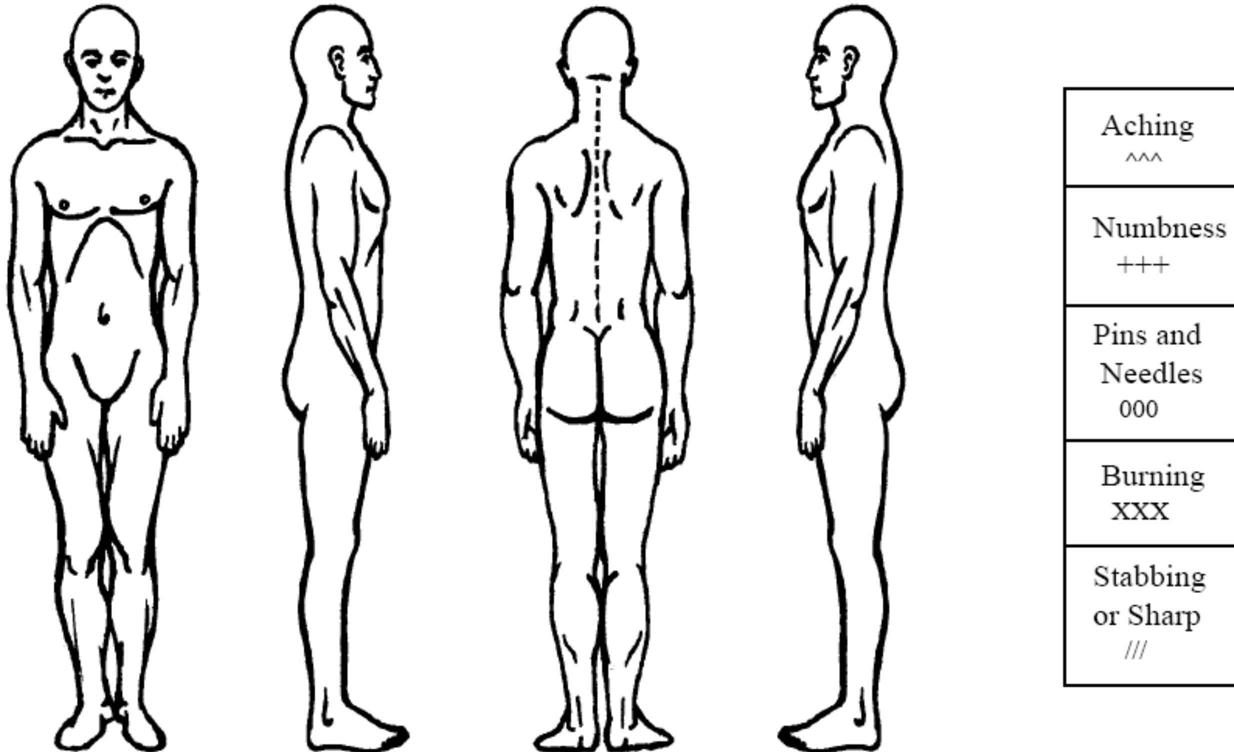
Did the injury occur at **WORK**? Yes____No___Date of injury:___________Time:____________

Has the injury been reported to your supervisor? Yes__No___Name of supervisor:__________________

Is the injury a result of an **AUTOMOBILE ACCIDENT**? Yes__No___**OTHER?**______________________

Name: ____________________

Please mark your areas of complaint on the diagrams below using the symbols on the right.



What problem is your biggest concern? ____________________

On the horizontal line below, draw a vertical line (|) denoting the severity of your worst pain:

No pain ____________________ Excruciating pain

How many days a week do you experience this problem? 1 2 3 4 5 6 7

What percentage of the time do you experience this problem? <25% 25% 50% 75% 100%

If you have more than 1 problem, which is the next worst? ____________________

Rate this pain in a similar fashion:

No pain ____________________ Excruciating pain

Signature ____________________ Date ____________________

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Name:____Date:______________________

* For the following conditions please check: ☐ for **previously** had, ○ for **presently** have.

General:

- ☐ ○ Alcoholism
- ☐ ○ Anemia
- ☐ ○ Cancer
- ☐ ○ High cholesterol
- ☐ ○ Diabetes
- ☐ ○ Epilepsy/Seizures
- ☐ ○ Thyroid
- ☐ ○ Gout
- ☐ ○ Hypoglycemia
- ☐ ○ Multiple sclerosis
- ☐ ○ Osteoarthritis
- ☐ ○ Parkinson's disease
- ☐ ○ Pneumonia
- ☐ ○ Polio
- ☐ ○ Rheumatic fever
- ☐ ○ Rheumatoid arthritis
- ☐ ○ Depression
- ☐ ○ Tuberculosis
- ☐ ○ Ulcers
- ☐ ○ Venereal Disease
- ☐ ○ Skin Problems

Resistance to infection:

- ☐ ○ Catch colds easily
- ☐ ○ Frequent sinus trouble
- ☐ ○ Frequent influenza

Gastrointestinal:

- ☐ ○ Gall bladder problem
- ☐ ○ Liver trouble/Hepatitis
- ☐ ○ Excessive thirst
- ☐ ○ Distress from greasy foods
- ☐ ○ Pain over Stomach
- ☐ ○ Burning in stomach relieved by eating
- ☐ ○ Burping or bloating (if bloating, where?)___________________
- ☐ ○ Heartburn
- ☐ ○ Nausea
- ☐ ○ Diarrhea
- ☐ ○ Blood in stool
- ☐ ○ Metallic taste in mouth
- ☐ ○ Mucus in stool
- ☐ ○ Colitis
- ☐ ○ Hiatal hernia
- ☐ ○ Vomiting
- ☐ ○ Constipation
- ☐ ○ Recent weight gain
- ☐ ○ Recent weight loss

Cardiovascular:

- ☐ ○ Pain over heart
- ☐ ○ Heart attack
- ☐ ○ Swelling in ankles
- ☐ ○ Irregular heartbeat
- ☐ ○ Stroke
- ☐ ○ Shortness of breath on exertion
- ☐ ○ Low blood pressure
- ☐ ○ High blood pressure
- ☐ ○ Pressure over chest

Nervous System:

- ☐ ○ Dizziness/Lightheaded
- ☐ ○ Fainting
- ☐ ○ Discoordination
- ☐ ○ Memory loss

Eye, Ear, Nose and Throat:

- ☐ ○ Vision problems
- ☐ ○ Hearing loss
- ☐ ○ Ear pain
- ☐ ○ Ear noises
- ☐ ○ Dental problems
- ☐ ○ Nose bleeds
- ☐ ○ Difficulty breathing through nose
- ☐ ○ Difficult speech
- ☐ ○ Hoarseness
- ☐ ○ Sore throat

Urinary Tract:

- ☐ ○ Blood in urine
- ☐ ○ Inability to control urination
- ☐ ○ Painful urination
- ☐ ○ Bladder infection
- ☐ ○ Kidney stones

Respiratory:

- ☐ ○ Chest pain
- ☐ ○ Coughing up blood
- ☐ ○ Difficulty breathing
- ☐ ○ Shortness of breath
- ☐ ○ Allergies
- ☐ ○ Chronic cough
- ☐ ○ Spitting up phlegm
- ☐ ○ Emphysema
- ☐ ○ Asthma

* For the following conditions please check: ☐ for **previously** had, ○ for **presently** have.

Women Only:

- ☐ ○ Irregular periods
- ☐ ○ Hot flashes
- ☐ ○ Vaginal discharge
- ☐ ○ Menopausal symptoms
- ☐ ○ Headaches with period
- ☐ ○ Menstrual cramps
- ☐ ○ Excessive flow
- ☐ ○ Hysterectomy
- ☐ ○ Premenstrual depression
- ☐ ○ Painful breasts
- ☐ ○ Lumps in breasts

Men Only:

- ☐ ○ Burning on urination
- ☐ ○ Prostate trouble
- ☐ ○ Feeling of incomplete bowel evacuation
- ☐ ○ Need to get up at night to urinate
- ☐ ○ Difficulty starting urine
- ☐ ○ Dripping after urination

Blood Sugar:

- ☐ ○ Irritable before meals
- ☐ ○ Heart palpitates if meals are missed/delayed
- ☐ ○ Get "shaky" if hungry
- ☐ ○ Awaken after a few hours sleep, hard to get back to sleep
- ☐ ○ "Lightheaded" if meals delayed
- ☐ ○ Moods of depression - "blues" or melancholy
- ☐ ○ Fatigue relieved by eating
- ☐ ○ Abnormal craving for sweets or snacks

Neuromusculoskeletal

- ☐ ○ Headaches
- ☐ ○ Upper extremity pain
- ☐ ○ Neck pain
- ☐ ○ Lower extremity pain
- ☐ ○ Low back pain
- ☐ ○ Tingling in hands or feet

Health Promotion Survey:

1. How are you sleeping?____

2. List any medications that you are taking:________________________________

3. List any dietary supplements (vitamins, herbs) that you are taking regularly:______________

____

4. Are you following a special diet?____________________________________

5. How many times a day do you usually eat?______________________________

6. What is your exercise program?____________________________________

____

7. Do you smoke?_______________Drink alcohol?________________________

   Have any other habits that affect your health?____________________________

8. Do you feel that you are under stress?________________________________

Signature:___________________________________Date:_________________