CONFIDENTIAL PATIENT INFORMATION

Personal Information

Name: First: Last: MI: **Date:**

Date of birth:	**Age:**

Address: Street: City: State: Zip:

Your Social security number:	**Home phone:**
Cell phone:	**Email address:**

Best time/place to contact you:

Marital status: ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced**

Spouse/ Guardian Name:	**Spouse's Employer & Occupation:**
Child's Name and Age:	**Child's Name and Age:**
Child's Name and Age:	**Child's Name and Age:**

Occupation:

Your Employer's name & address:

Emergency Contact: First: Last: Phone:

Who may we thank for referring you? ____________________

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Have you ever filed a Worker's Compensation Claim for any of the injuries you are currently seeking treatment for?___________

Quality of Symptoms (What does it feel like?) Check all that apply:

☐Numbness ☐Tingling ☐Stiffne ☐Dull ☐Aching ☐Cramps ☐Nagging

☐Sharp ☐Burning ☐Shooti ☐Throbbing ☐Stabbing ☐Other_______________

Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

Current Medicines and Supplements

Please list any medications/drugs, nutritional supplements, vitamins, homeopathic remedies you have taken in the past 6 months and why: (prescription and non-prescription)

The type of diet I usually follow is classified as: ____________________

Past Health History Please mark the following conditions you may have had or have now (**-** have had/ **+** have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐ Multiple Sclerosis	☐ Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐ Sinus Problem
☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough
☐ Surgery	☐ Auto Accident	☐ Work Related Injury	☐ Slip and Fall		

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category: ***Please pay close attention to this as it will help us help you!***

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____________________
   b. ____________________
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____________________
   b. ____________________
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____________________
   b. ____________________

On a scale of 1-10 (10 being highest) please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Why are you here at this point in time? ____________________

I consent to a professional and complete examination and to any radiographic examination or diagnostic testing that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name:____________________ Date: ____________________

Signature: ____________________