ACCT# _____ PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT.

Patient:

Full Name _____ Preferred Name _____ Sex: M F

Home Phone _____Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status (Circle One) S M W D Sep Number of Children ____

SSN# _____-____-_____ Driver's License Number _____

Email Address _____

Employer _____ Occupation _____ Number of Years _____

Employer Address _____ City _____ State ____ Zip Code _____

Insurance:

Do you have Health Insurance? Yes ____ No ____ Are you the subscriber? Yes ____ No ____

Name of subscriber (if not you) _____ Subscriber Date of Birth _____

Insurance Company _____

Subscriber ID# _____ Plan/Group# _____

Is your condition today due to an accident? Yes ____ No ____ Date of Accident _____

How did you find out about our office?

Many of our patients find us because someone referred them here. If someone referred you, please leave their name so we can give them a thank you gift!

☐ Friend or family recommendation. Name _____ ☐ Doctor referral. Name _____
☐ Google Search ☐ Facebook ☐ Mailer/Postcard ☐ Drove By ☐ Other _____

In case of Emergency:

Name of Spouse, Parent or Guardian, or other Emergency Contact:_____

Contact's Employer _____ Contact's Phone Number _____

I agree that a photo static copy of this agreement shall serve as the original.

Patient or Guardian Signature _____ Date _____

****Notice to our new patients: Full payment for services rendered is due at the end of each visit****

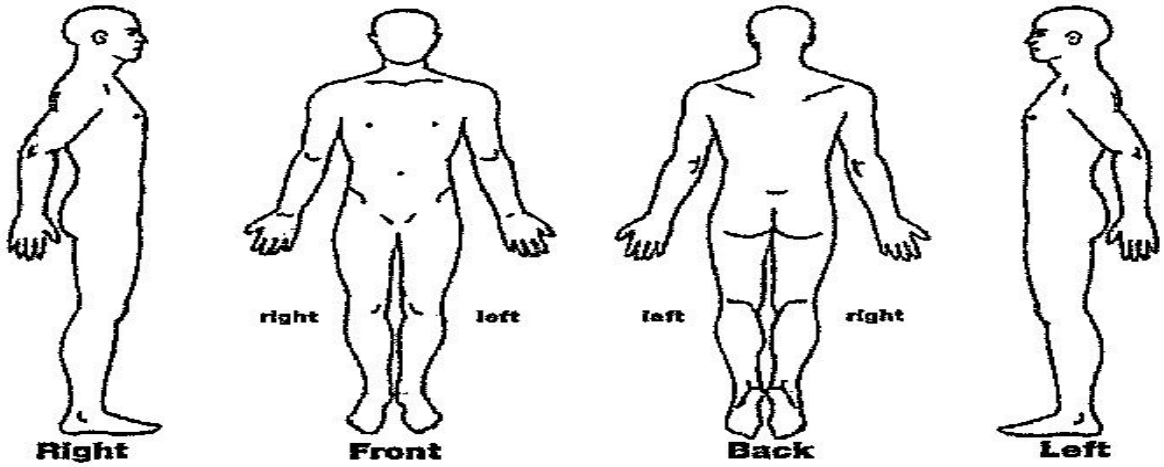
Problem Focused History

Name _____ Age _____ Sex: M F Date _____

What brings you into our office today? (Please Explain) _____

_____

Please indicate the location of your symptoms, injury or pain:



1. When did your symptoms start? _____
2. How did your symptoms start? _____
3. Rate your pain or symptoms on a scale of 1-10, 1 is barely noticeable, and 10 is emergency-room level pain or symptoms
   1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
4. Has your pain spread or radiated anywhere: Yes____ No ____
   If so where? _____
5. Have your symptoms changed since onset? Yes ____ No ____
   Decrease ____ Increased ____ Come and Go ____
6. Have you noticed any change in bodily functions? Yes ____ No ____ (Please check those that apply)
   ____ Balance/coordination ____ Bowel Habits ____ Breathing ____ Hearing
   ____ Coughing/sneezing ____ Walking ____ Grip Strength ____ Menstrual
   ____ Sexual ____ Urination ____ Vision ____ Weakness
7. Handedness: Right ____ Left ____ Ambidextrous ____
8. This issue is affecting my:
   ____ Childcare ____ Job ____ Marriage ____ Finances
   ____ Exercise ____ Hobby ____ Stress Level ____ Mood
   Please identify up to 3 activities that you are unable to do or are having difficulty with as a result of this issue:
   1. _____
   2. _____
   3. _____

9. Work Status: Full Time ____ Student ____ Unemployed ____ Retired ____ Disabled _____
10. Work/Home Disability: Yes ____ No ____
    Complete: ____ Days off work
    ____ Days unable to perform Household tasks
    ____ Days of job modification
    ____ Days of decreased household tasks
11. Have you been treated by anyone else for this problem? Yes ____ No ____
    If so, please identify who and what type of therapy? _____
    _____
12. Are you currently under a doctor's care for any <u>other</u> conditions? Yes ____ No ____
    If so, please explain: _____
13. Have you suffered any physical injuries such as falls or blows, whiplash, concussion, or head injury, lacerations, sprains, strain, dislocations, broken or cracked bones? Yes ____ No ____
    Please explain: _____
14. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    1. _____ Date _____
    2. _____ Date _____
    3. _____ Date _____
    4. _____ Date _____
15. Have you ever been hospitalized for any reason other than surgery? Yes ____ No ____
    Explain: _____
16. Do you have any nervous system diseases and/or mental health problems? Yes ____ No ____
    Explain: _____
17. Do you have any muscle, tendon or ligament problems (ex. arthritis, osteoporosis etc.)?
    Yes ____ No ____ Explain: _____
18. Do you have any gland or hormone problems? Yes ____ No ____ Explain: _____
19. Have you ever had cancer? Yes ____ No ____ Explain Type: _____
20. Have you lost weight without trying? Yes ____ No ____ How much? _____
21. Does your pain wake you up at night? Yes ____ No____
22. Have you recently had any unusual bleeding or discharge? Yes ____ No ____
23. Medications: Please list all medications (prescription and non-prescription) you are currently taking or take on an occasional basis:
    1. _____ Dose _____ Frequency _____
    2. _____ Dose _____ Frequency _____
    3. _____ Dose _____ Frequency _____
    4. _____ Dose _____ Frequency _____
    5. _____ Dose _____ Frequency _____
24. Do you have any allergies to medication? Yes ___ No ___ Explain: _____
25. Are there any diseases or conditions that are common among your family members (I.E. Inherited diseases or conditions, Mother, Father, Maternal Grandparents, or Paternal Grandparents)? Yes ____ No ____ If yes, please explain: _____
    _____
26. **Do you have a Pacemaker or any other Surgically Implanted Device? Yes ____ No ____**
27. **Females: Are you now or could you be pregnant? Yes ___ No ___**
    Date of last menstrual cycle _____ Are you on birth control? Yes ___ No ___

Anything else that you would like to tell us, please do so here: _____
_____
_____

Medical History

Indicate any of the following you have experienced in the PAST FEW WEEKS

☐ Dizziness	☐ Shoulder Pain	☐ Abdominal Pain
☐ Angina (chest pain)	☐ Elbow pain	☐ Allergies
☐ Headache	☐ Hand Pain	☐ Irritable Bowel
☐ Visual changes	☐ Wrist Pain	☐ Constipation
☐ Kidney Stones	☐ Hip Pain	☐ Diarrhea
☐ Complete loss of bowel or bladder control	☐ Jaw Pain	☐ Nausea
☐ Drug Abuse	☐ Knee pain	Male Only
☐ Fever	☐ Neck Pain	☐ Testicular pain
☐ Head Trauma	☐ Ankle Pain	☐ Groin Pain
☐ Leg or arm weakness	☐ Back Pain	Female Only
	☐ Foot Pain	☐ Abnormal/painful menstruation

Indicate which of the following you have EVER had

☐ Stroke	☐ High Cholesterol	☐ Epilepsy
☐ Unexpected weight loss	☐ Gout	☐ Lupus
☐ Spinal Surgery	☐ Hormone therapy	☐ Hypothyroidism
☐ Fractured Vertebrae	☐ Inflammatory Bowel Disease	☐ Hyperthyroidism
☐ Cancer _____	☐ Liver Condition	☐ Bleeding Disorder
☐ Kidney Stones	☐ Gallbladder Condition	☐ Ulcer
☐ Rheumatoid Arthritis	☐ Mental Illness	☐ Herniated discs
☐ Arthritis	☐ Prostatitis (male only)	☐ Bulging discs
☐ Psoriasis	☐ Neurological Disorder	☐ Varicose Veins
☐ HIV / AIDS	☐ Diabetes	☐ Numbness
☐ Tumor	☐ Sinus Condition	☐ Other health condition: _____
☐ Heart Disease	☐ Depression	
☐ High Blood Pressure		

Please list any supplements you take: _____

_____

Current Dietary Restrictions / food allergies: _____

Current Exercise habits: _____

In an effort to keep your health information up to date and to keep your Primary Care Physician (PCP) informed of the health care you receive in our office we are requesting your authorization to release your health records to your PCP.

PCP Name: _____

PCP Practice Name: _____

PCP Phone Number: _____

Your Signature: _____