FOR OFFICE USE ONLY: ▫S.O.F. ▫Folder ▫Referral ▫E-3 x 5 ▫Copy Insurance Card .

CONFIDENTIAL PATIENT DATA

If you need assistance completing this form, please ask the receptionist

PATIENT INFORMATION

TODAYS DATE: ______________

Name: ______________
Address: ______________
City: ______________
Home Phone: (_____) ________-______________
Date of Birth: ______________
Social Security Number: ______________
Occupation: ______________
Work Phone: (_____) ________-______________
Marital Status: □ Single □ Married □ Separated □ Divorced □ Other
Name of Spouse or Nearest Relative: ______________

□ Male □ Female
State: ______________ Zip: ______________
E-mail Address: ______________
Cell Phone: ______________
Age: ________ Height: ________ Weight: ________
Employer: ______________
Phone of Relative: (_____) ________-______________

Referred to this office by:
□ Family Member ______________
□ Friend / Co-Worker ______________
□ Attended Seminar ______________
□ Yellow Pages ______________
□ Convenient Location ______________
□ Advertisement ______________
□ Other ______________

MEDICAL HISTORY

SURGICAL HISTORY:

1. ______________ AGE: _______ DATE: ________
2. ______________ AGE: _______ DATE: ________
3. ______________ AGE: _______ DATE: ________

ACCIDENT HISTORY:

1. ______________ AGE: _______ DATE: ________
2. ______________ AGE: _______ DATE: ________
3. ______________ AGE: _______ DATE: ________

PLEASE DESCRIBE **PRESENT MAJOR COMPLAINTS**
with #1 as the primary reason you are seeking care

Please rate the symptoms from 1-10 with 1 as mild and 10 as severe

1. ______________ ______________
2. ______________ ______________
3. ______________ ______________

Symptoms began on the day of: ______________
Symptoms developed from: ______________
□ Job Related □ Auto Injury □ Other Accident □ Illness □ Gradual Onset □ Unknown Cause
Date of last physical exam: ______________
Have you been treated by a physician for this or any other health condition in the last year? □ Yes □ No
Describe Condition: ______________
Name(s) and location(s) of Doctor(s) previously seen for present condition(s):
____
____

Are you taking any prescription medications? □Yes □No
Please describe the condition that the medication is for:
Medication: ______________ Condition: ______________
Medication: ______________ Condition: ______________
Medication: ______________ Condition: ______________

Are you taking any over-the-counter medications? □Yes □No
Please describe the condition that the medication is for:
Medication: ______________ Condition: ______________
Medication: ______________ Condition: ______________
Medication: ______________ Condition: ______________

Are you taking any supplements or vitamins? □Yes □No
Please describe the condition that the supplement is for:
Supplement: ______________ Condition: ______________
Supplement: ______________ Condition: ______________
Supplement: ______________ Condition: ______________

- please complete other side -

PLEASE MARK ALL **PAST AND PRESENT** CONDITIONS:

	Past	Present		Past	Present
AIDS	□	□	High Blood Pressure	□	□
Allergies	□	□	HIV	□	□
Anemia	□	□	Indigestion	□	□
Arthritis	□	□	Kidney Disease	□	□
Asthma	□	□	Liver Disease	□	□
Back Pain	□	□	Lymes Disease	□	□
Bladder Trouble	□	□	Migraines	□	□
Bone Fracture	□	□	Mononucleosis	□	□
Bowel Disease	□	□	Multiple Sclerosis	□	□
Cancer	□	□	Muscular dystrophy	□	□
Chemotherapy	□	□	Nausea	□	□
Chest Pain	□	□	Neck Pain	□	□
Chronic Fatigue	□	□	Nervousness	□	□
Concussion	□	□	Numbness/Tingling	□	□
Constipation	□	□	Polio	□	□
Convulsions	□	□	Poor Circulation	□	□
Diabetes	□	□	Radiation Therapy	□	□
Diarrhea	□	□	Reproductive Disorders	□	□
Dislocated Joints	□	□	Rheumatoid Arthritis	□	□
Dizziness / Vertigo	□	□	Seizures	□	□
Epilepsy	□	□	Stomach Problems/Acid Reflux	□	□
Fibromyalgia	□	□	Tire Easily	□	□
Headaches	□	□	Tuberculosis	□	□
Heart Trouble	□	□	Ulcer	□	□
Hepatitis	□	□	Venereal Disease	□	□

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

□Cold Feet	□Blurred Vision	□Catches Colds Easily	□Ringing / Buzzing in Ears
□Cold Hands	□Muscle Jerking	□Numbness in Toes	□Pins and Needles in Arms
□Cold Sweats	□Face Flushed	□Numbness in Fingers	□Pins and Needles in Legs
□Fever	□Fatigue	□Loss of Balance	□Eyes Sensitive to Light
□Fainting	□Insomnia	□Loss of Taste	□Depression / Weeping Spells
□Sleep Apnea	□Upset Stomach	□Loss of Smell	□Loss of Concentration / Confusion
□Stiff Neck	□Shortness of Breath	□Head Seems Heavy	□Other: ______________________

Have you ever had a metal implant? □ Yes □ No

Have you ever had a gunshot wound? □ Yes □ No

□Other: ______________________

□Other: ______________________

Family History:	Mother	Father	Siblings
Allergies	_______	_____	________
Asthma	_______	_____	________
Heart Disease	_______	_____	________
Cancer	_______	_____	________
Arthritis	_______	_____	________
Kidney Disease	_______	_____	________
Diabetes	_______	_____	________
Stomach / Digestive Disorders	_______	_____	________

For Women Only: Are You Pregnant? Yes / No / I'm not sure Date of last period: ______________

PMS Yes / No Menstrual Cramps Yes / No Miscarriage(s) Yes / No

Patient Signature: ____ Date: ____________________