

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.

Name _____ Nickname _____ Home Phone _____

Cell Phone _____ E-mail Address _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D No. of Children _____

Who Referred you to this office _____

Your Employer _____ Occupation _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Name of Spouse or Parent _____ Birth Date _____

Work Phone _____ Spouse SS# _____

Spouse employed by _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance Company _____ Policy Holder Self / Spouse / Other _____

Secondary Insurance Company _____ Policy Holder Self / Spouse / Other _____

Is this an accident? Y or N If so, Date of Injury _____

() Auto Accident () On the Job Injury have you reported this Y / N () other Attorney _____

How did you get injured? _____

List all complaints in order of severity

- | | | | |
|----------|--------------------|---------------------|--------|
| 1. _____ | For how long _____ | Is it getting worse | Y or N |
| 2. _____ | For how long _____ | Is it getting worse | Y or N |
| 3. _____ | For how long _____ | Is it getting worse | Y or N |
| 4. _____ | For how long _____ | Is it getting worse | Y or N |
| 5. _____ | For how long _____ | Is it getting worse | Y or N |

Doctors consulted for above complaints _____

Primary Care Physician _____

In order to coordinate the best health care would you like us to send a report to your Primary Care Physician: Yes / No

I understand that I am financially responsible for all charges for services rendered. I understand and agree that health and 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 non covered in compliance with any insurance policy. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Any bills not paid in a timely manner may be turned over to a collection agency and I will be responsible for any and all collection charges, attorney fees, court costs, and any other fees that may apply.

Notice to our 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 assignments the deductible must be met in the beginning unless prior arrangements are made.

Please circle one payment type: Cash Check Master Card/Visa

Patient/Guardian's Signature _____ Date _____

Patient Name _____

Date _____

<u>Cardiovascular:</u>	Current	Past	<u>Eyes:</u>	Current	Past	<u>Neck</u>	Current	Past
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in neck	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Neck feels out of place	<input type="checkbox"/>	<input type="checkbox"/>
Aortic aneurism	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasm in neck	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<u>Integumentary:</u>			Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Grinding sounds in neck	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	Popping sounds in neck	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Limited neck movement	<input type="checkbox"/>	<input type="checkbox"/>
Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain with movement	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in neck	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psychiatric:</u>			Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Pinched nerve in neck	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<u>Shoulders</u>		
<u>Genitourinary:</u>			Unusual stress	<input type="checkbox"/>	<input type="checkbox"/>	Pain in shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<u>Constitutional:</u>			Can't raise arm above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>
Lower side pain	<input type="checkbox"/>	<input type="checkbox"/>	Weigh loss / gain	<input type="checkbox"/>	<input type="checkbox"/>	head	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Energy level problem	<input type="checkbox"/>	<input type="checkbox"/>	Pain across shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Tension in shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergic/Immunologic:</u>			Muscle spasms in shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<u>Arms & Hands</u>		
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Immune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pain in upper arm	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hematologic / Lymphatic:</u>			HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pain in hands	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergy shots	<input type="checkbox"/>	<input type="checkbox"/>	Fingers go to sleep	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone use	<input type="checkbox"/>	<input type="checkbox"/>	Pain in fingers	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Visceral disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hands cold	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal:</u>			Sore joints in fingers	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints in fingers	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/chills/sweats	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Loss of grip strength	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurologic:</u>			Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain in elbow	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in forearm	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sensation of pins & needles	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	In arms	<input type="checkbox"/>	<input type="checkbox"/>
Brain aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	In fingers	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<u>Mid Back</u>		
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>
Pinched nerves	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine:</u>			Pain from front to back	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Dull ache	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain over kidney area	<input type="checkbox"/>	<input type="checkbox"/>
Spinning/balance	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasm in mid back	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulder blades	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory:</u>			Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	Sharp stabbing pain	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<u>Head</u>			<u>Low Back</u>		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Unusually frequent headache	<input type="checkbox"/>	<input type="checkbox"/>	Low back feels out of place	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms in low back	<input type="checkbox"/>	<input type="checkbox"/>
Cold/flu	<input type="checkbox"/>	<input type="checkbox"/>	Light headedness	<input type="checkbox"/>	<input type="checkbox"/>	<u>Hips Legs & Feet</u>		
Cough/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Pain in buttocks	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	Pain in feet	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ear / nose / throat:</u>			Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ankles	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pain in toes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Unusually severe headache	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	Head feels heavy	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>				Cold feet	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>				Numbness in leg	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>				Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>				Numbness in toes	<input type="checkbox"/>	<input type="checkbox"/>
						Swollen feet	<input type="checkbox"/>	<input type="checkbox"/>
						Pain down legs	<input type="checkbox"/>	<input type="checkbox"/>
						Knee pain	<input type="checkbox"/>	<input type="checkbox"/>
						Pins and needles in legs	<input type="checkbox"/>	<input type="checkbox"/>
						Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>
						Disc problems	<input type="checkbox"/>	<input type="checkbox"/>
						Gout	<input type="checkbox"/>	<input type="checkbox"/>
						<u>General</u>		
						Poor posture	<input type="checkbox"/>	<input type="checkbox"/>
						Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
						Swelling	<input type="checkbox"/>	<input type="checkbox"/>
						Numbness	<input type="checkbox"/>	<input type="checkbox"/>
						Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

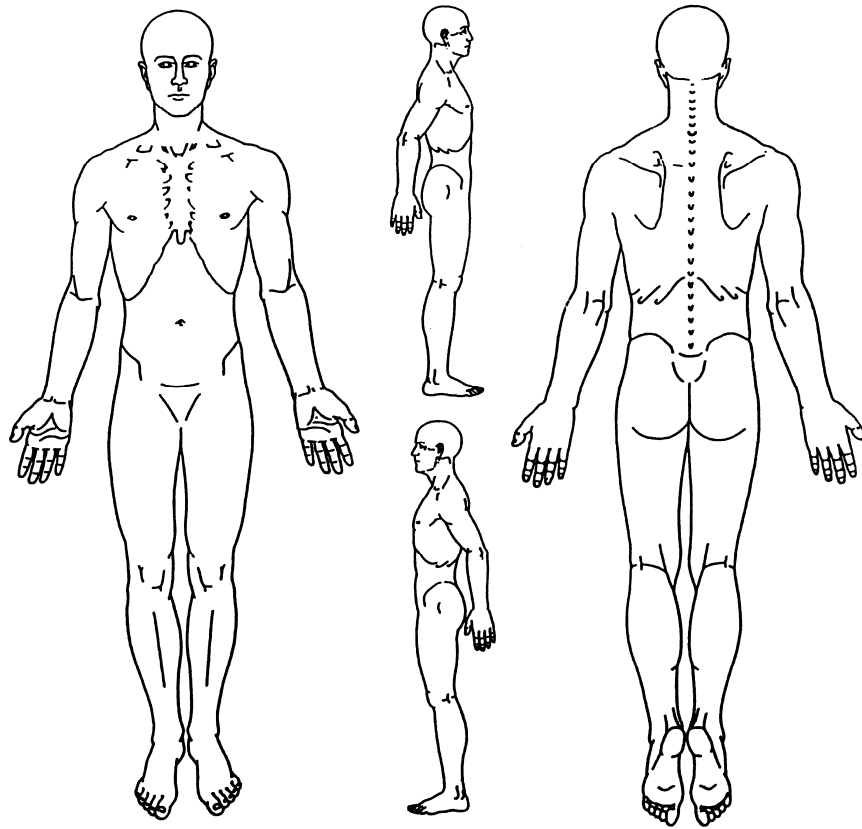
Patient Name _____ Date _____

On the picture below, please use the following letters to indicate TYPE and LOCATION of the pain you currently are experiencing.

A= Ache
O= Other

B= Burning
P= Pins & Needles

N= Numbness
S= Stabbing / Sharp



Complaints	No Pain										Moderate Pain										Severe Pain												
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
1 _____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
2 _____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
3 _____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
4 _____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
5 _____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10