PATIENT INFORMATION

DATE:_____

NAME:_____ CELL PHONE #_____

ADDRESS:_____ E-MAIL:_____

CITY:_____ STATE:_____ ZIP_____

HOME PHONE:_____ WORK PHONE:_____

AGE:_____ BIRTHDATE:_____ SOCIAL SECURITY #_____

SEX: M F MINOR SINGLE MARRIED SEPARATED DIVORCED WIDOWED

YOUR EMPLOYER:_____

OCCUPATION:_____ YEARS ON JOB:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SPOUSE INFORMATION:

SPOUSE'S NAME:_____

SPOUSE EMPLOYED BY:_____

OCCUPATION:_____ YEARS ON JOB:_____

SPOUSE'S EMPLOYER'S ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____ PHONE :_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

IN CASE OF AN EMERGENCY:

(Name of relative or close friend not living in your home)

NAME:_____ RELATIONSHIP TO YOU:_____

ADDRESS:_____ PHONE #_____

WHOM MAY WE THANK FOR REFERRING YOU?

NAME:_____ RELATIONSHIP TO YOU_____

PAYMENT INFORMATION:

PLEASE CIRCLE ONE PAYMENT TYPE:

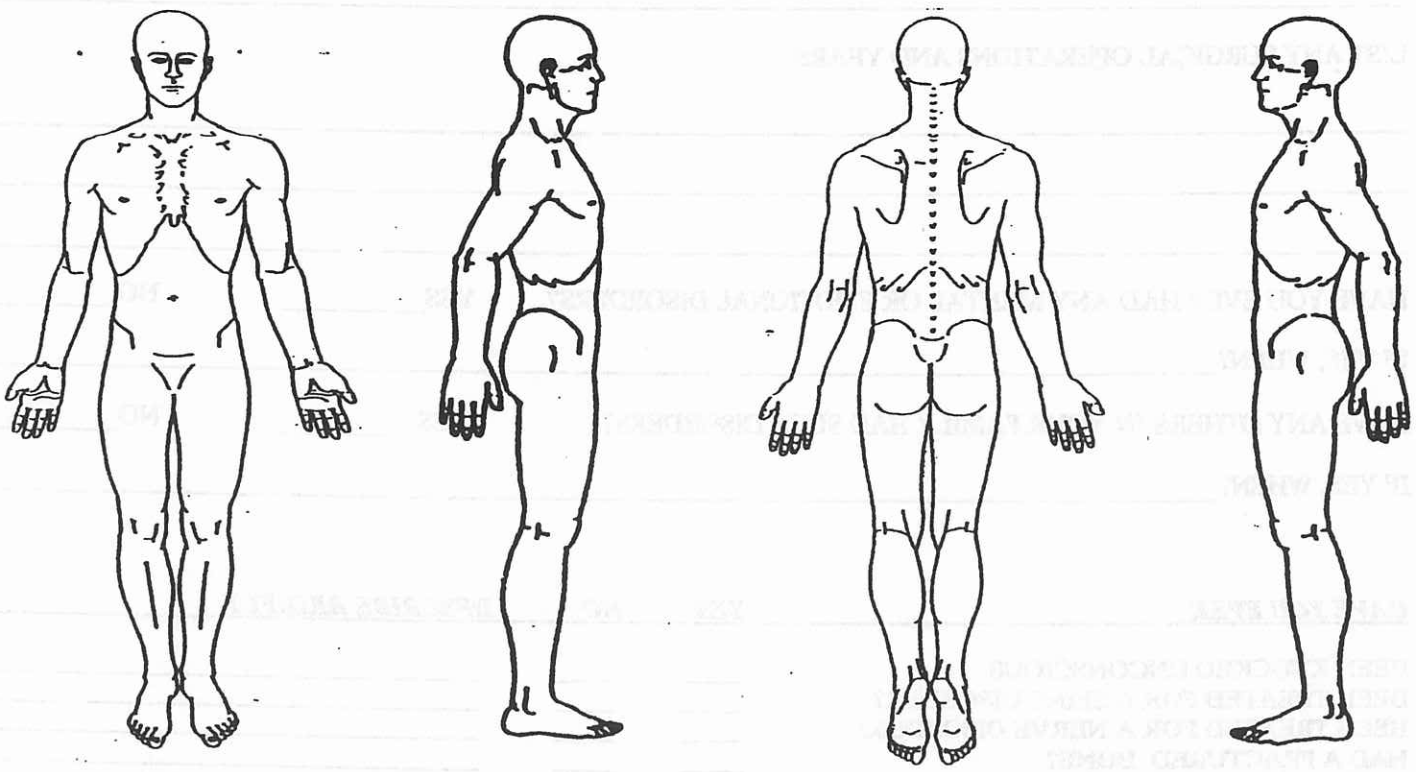
CASH CHECK MASTERCARD VISA DISCOVER

DO YOU HAVE INSURANCE? _____

DO YOU HAVE MEDICARE? _____

IF YOU WILL GIVE US YOUR INSURANCE CARD(s), WE WILL MAKE A COPY FOR YOUR FILE....

COMPLETE THESE DIAGRAM:
(PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAMS)



ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE: DULL, SHARP, CONSISTENT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

_____

_____

_____

_____

_____

PLEASE LIST ANY CONDITIONS YOU ARE BEING TREATED FOR:

_____

_____

_____

IS YOUR CONDITION DUE TO AN ACCIDENT? _____ DATE OF ACCIDENT:_____

TYPE OF ACCIDENT? AUTO _____ WORK/ON JOB_____ AT HOME_____ OTHER_____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? _____

IF YES, WHEN? PAST YEAR_____ PAST 5 YEARS_____ OVER 5 YEARS_____ NEVER_____

WHAT IS YOUR MAJOR COMPLAINT?_____

_____

_____

LIST ANY SURGICAL OPERATIONS AND YEARS:

_____

_____

_____

HAVE YOU EVER HAD ANY MENTAL OR EMOTIONAL DISORDERS? YES_____ NO_____

IF YES, WHEN?_____

HAVE ANY OTHERS IN YOUR FAMILY HAD SUCH DISORDERS? YES_____ NO_____

IF YES, WHEN?_____

HAVE YOU EVER	***YES***	***NO***	***DESCRIBE BRIEFLY***
BEEN KNOCKED UNCONSCIOUS	___	___	_____
BEEN TREATED FOR A SPINE DISORDER?	___	___	_____
BEEN TREATED FOR A NERVE DISORDER?	___	___	_____
HAD A FRACTURED BONE?	___	___	_____
BEEN HOSPITALIZED FOR ANYTHING OTHER THAN SURGERY?	___	___	_____
DO YOU			
NOW TAKE VITAMINS OR MINERALS?	___	___	_____
THINK YOU NEED VITAMINS / MINERALS?	___	___	_____
HAVE AN ALLERGY TO ANY DRUG?	___	___	_____

DATE OF LAST:	***LESS THAN 6 MONTHS***	***6-18 MONTHS***	***OVER 18 MONTHS***	***NEVER***
SPINAL EXAMINATION	___	___	___	___
PHYSICAL EXAMINATION	___	___	___	___
BLOOD TEST	___	___	___	___
CHEST X-RAY	___	___	___	___
SPINAL X-RAY	___	___	___	___
URINE TEST	___	___	___	___

HABITS:	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL	___	___	___	___
COFFEE	___	___	___	___
TOBACCO	___	___	___	___
DRUGS	___	___	___	___
EXERCISE	___	___	___	___
SLEEP	___	___	___	___

PLEASE CIRCLE THE APPROPRIATE ANSWER FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. WE WANT ALL THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE. THIS IS A CONFIDENTIAL HISTORY REPORT.

O - OCCASIONAL **F - FREQUENT** **C - CONSTANT**

GENERAL

O F C Allergy
O F C Chills
O F C Convulsions
O F C Dizziness
O F C Fainting
O F C Fatigue
O F C Fever
O F C Headache
O F C Loss of sleep
O F C Loss of weight
O F C Nervousness
O F C Depression
O F C Neuralgia
O F C Numbness
O F C Sweats
O F C Tremors

MUSCLE & JOINT

O F C Arthritis
O F C Bursitis
O F C Foot trouble
O F C Hernia
O F C Low back pain
O F C Lumbago
O F C Neck pain
O F C Neck stiffness
O F C Pain between shoulders

PAIN/NUMBNESS IN:

O F C Shoulders
O F C Arms
O F C Elbows
O F C Hands
O F C Hips
O F C Legs
O F C Knees
O F C Feet
O F C Painful tail bone
O F C Poor posture
O F C Sciatica
O F C Spinal curvature
O F C Swollen joints

GASTRO-INTESTINAL

O F C Belching or gas
O F C Colitis
O F C Colon trouble
O F C Constipation
O F C Diarrhea
O F C Difficult digestion
O F C Distension of Abdomen
O F C Excessive hunger
O F C Gall bladder trouble
O F C Hemorrhoids
O F C Intestinal worms
O F C Jaundice
O F C Liver trouble
O F C Nausea
O F C Pain over stomach
O F C Poor appetite
O F C Vomiting
O F C Vomiting blood

EYES, EARS, NOSE AND THROAT

O F C Asthma
O F C Colds
O F C Crossed eyes
O F C Deafness
O F C Dental decay
O F C Earache
O F C Ear discharge
O F C Ear noises
O F C Enlarged glands
O F C Enlarged thyroid
O F C Eye pain
O F C Failing vision
O F C Far sightedness
O F C Gum trouble
O F C Hay fever
O F C Hoarseness
O F C Nasal obstruction
O F C Near sightedness
O F C Nosebleeds
O F C Sinus infection
O F C Sore throat
O F C Tonsillitis

CARDIO-VASCULAR

O F C Hardening of arteries
O F C High blood pressure
O F C Low blood pressure
O F C Pain over heart
O F C Poor circulation
O F C Rapid heart beat

RESPIRATORY

O F C Chest pains
O F C Chronic cough
O F C Difficult breathing
O F C Spitting up blood
O F C Spitting up phlegm
O F C Wheezing

SKIN

O F C Boils
O F C Bruise easily
O F C Dryness
O F C Hives / Allegy
O F C Itching
O F C Skin eruptions (rash)
O F C Varicose veins

GENITO-URINARY

O F C Bed-wetting
O F C Blood in urine
O F C Frequent urination
O F C Inability to control kidneys
O F C Kidney infection
O F C Kidney stones
O F C Painful urination
O F C Prostate trouble
O F C Pus in urine

FOR WOMEN ONLY

O F C Congested breasts
O F C Cramps
O F C Backaches
O F C Excessive menstrual flow
O F C Hot flashes
O F C Irregular cycles
O F C Menopausal symptoms
O F C Painful menstruation
O F C Vaginal discharge

ARE YOU PREGNANT?_____

NUMBER OF CHILDREN_____