OREGON HEAD & NECK
243 SW Scalehouse Loop, Suite 1A
Bend, OR 97702
(541) 213-2190

TODAY'S DATE_____

Last Name _____First Name _____ M.I._____

Street Address _____

City _____ State _____ Zip Code_____

Date of Birth_____ Age _____ Marital Status: S M W No. Children _____

Home Phone _____ Mobile Phone _____

Email _____

Employer _____Occupation _____

Emergency Contact _____ Phone Number _____

How did you hear about our office?

_____

Were you injured on the job? No Yes When? _____

Were you injured in an auto accident? No Yes When? _____

Describe your present problem

_____

Have you ever had this problem before? No Yes When? _____

When did the problem begin?

_____

Other conditions:

_____

Date of Last exam _____ Are you pregnant? _____

Reason for seeking care? _____

What are your goals for care? _____

In general would you say your health is: Poor Fair Good Very Good

Please check the following habits (H = Heavy; M = Moderate; L = Light N = N/A) Circle One

Tobacco H M L N Alcohol H M L N Coffee H M L N

Drugs H M L N Overeating H M L N

Please indicate if you have a serious or chronic medical condition: (Circle all that apply)

Neck Pain Migraines Asthma Diabetes Heart Disease Cancer Fatigue Thyroid Allergies
Headaches Dizziness Arm Pain Numbness Chest Pain Back Pain Ulcers Colitis Sciatica
Arthritis Low Bld. Pressure High Bld. Pressure Gout High Cholesterol Anxiety/Depression PTSD

Joint Swelling Freq. Urination Constipation Diarrhea Sinus Problems HIV Positive Neck Tension

Digestive Disorders Nose Bleeds Pain Between Shoulders Anemia Hot Flashes Bursitis
Crohn's Disease Nervousness Polio Sleeping Problems Goiter Fertility Problems IBS ADD/ADHD

Please list any known food sensitivity or allergy:

_____

_____

_____

Other conditions, please specify:

_____

Any other health concerns?

_____

Prescriptions?

_____

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? No Yes

If so please describe:

_____

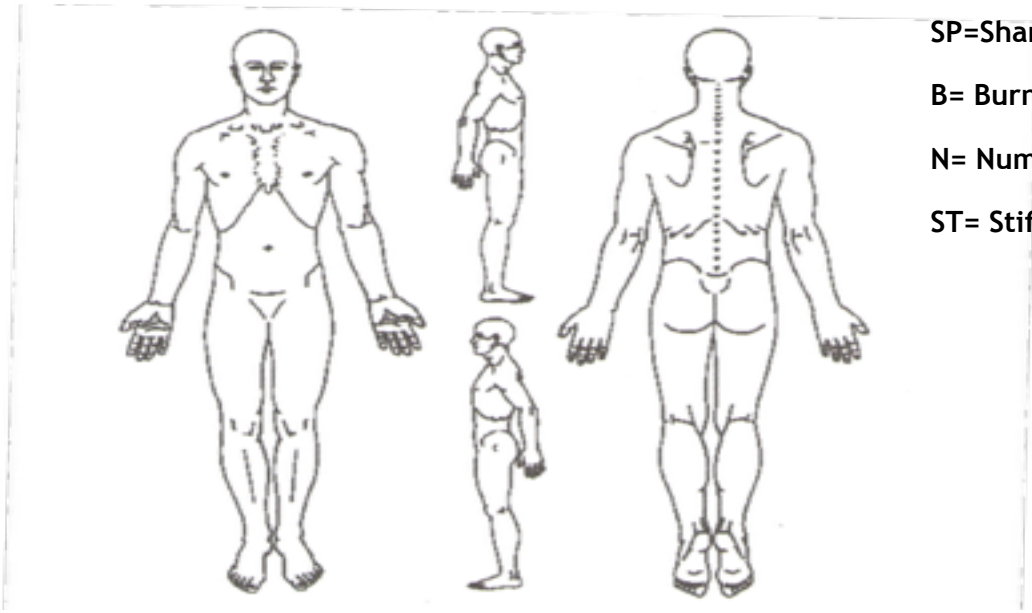
List your top 3 health complaints/concerns:

1._____

2._____

3._____

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area using the abbreviations on the diagram below, along with a pain rating from the above scale.



SP=Sharp Pain **DP= Dull Pain**

B= Burning **S= Stinging**

N= Numbness **T= Tingling**

ST= Stiffness **A= Abnormal Sensation**

Patient's Signature _____ Date _____

Guardian's Signature_____ Date _____
(If patient is a minor.)

Physician's Signature_____ Date _____