CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's date:

PATIENT INFORMATION

Patient's Last name: First: Middle Initial:	Nickname:	Date of Birth:	Sex: ❑M ❑F

Street address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:

Preferred Phone: ❑Home ❑Work ❑Cell	Social Security#	Email:

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced ❑Partnered ❑Other_____

Referred to Our Office By: ❑Friend/Family_____
❑Clinic Location ❑Online_____ ❑Yellow Pages ❑Health Insurance ❑Other_____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑ Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year ____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
4. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
5. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:
1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

Referring Physician?:

Alcohol Use: ❑None ❑Light ❑ Moderate ❑Heavy	Drug Use: ❑None ❑Light ❑ Moderate ❑Heavy	Exercise: ❑None ❑Light ❑ Moderate ❑Heavy

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Secondary Insurance	Insured ID

EMERGENCY CONTACT

Name:_____Relationship:_____Phone:_____

FAMILY HISTORY							
Please indicate which conditions exist or have existed by marking the boxes below.							
	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	❑	❑	❑	❑	❑	❑	❑
Brain Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑	❑
Gastric Cancer	❑	❑	❑	❑	❑	❑	❑
Kidney Cancer	❑	❑	❑	❑	❑	❑	❑
Leukemia	❑	❑	❑	❑	❑	❑	❑
Liver Cancer	❑	❑	❑	❑	❑	❑	❑
Muscle Cancer	❑	❑	❑	❑	❑	❑	❑
Other Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Rectal Cancer	❑	❑	❑	❑	❑	❑	❑
Skin Cancer	❑	❑	❑	❑	❑	❑	❑
Thyroid Cancer	❑	❑	❑	❑	❑	❑	❑
Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Deep Vein Thrombosis	❑	❑	❑	❑	❑	❑	❑
Pulmonary Embolism	❑	❑	❑	❑	❑	❑	❑
Unknown Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia/Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Gestational Diabetes	❑	❑	❑	❑	❑	❑	❑
Impaired Fasting Glucose	❑	❑	❑	❑	❑	❑	❑
Insulin Resistance	❑	❑	❑	❑	❑	❑	❑
Maturity onset Diabetes (MODY)	❑	❑	❑	❑	❑	❑	❑
Pre-Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 1 Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 2 Diabetes	❑	❑	❑	❑	❑	❑	❑
Colon Polyp	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑
Familial adenomatous polyposis (FAP)	❑	❑	❑	❑	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑	❑	❑
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	❑
Lynch Syndrome	❑	❑	❑	❑	❑	❑	❑
Angina	❑	❑	❑	❑	❑	❑	❑
Coronary Artery Disease	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Heart Disease	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Cystic Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Chronic Kidney Disease (assoc. Diabetes Type 2)	❑	❑	❑	❑	❑	❑	❑
Congenital Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Kidney Nephrosis	❑	❑	❑	❑	❑	❑	❑
Nephritis	❑	❑	❑	❑	❑	❑	❑
Nephrotic Syndrome	❑	❑	❑	❑	❑	❑	❑
Other Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑

COPD	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑
Chronic Lower Respiratory Disease	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑
Influenza	❑	❑	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑	❑	❑
Bipolar Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑	❑	❑
Mental Disorder	❑	❑	❑	❑	❑	❑	❑
OCD	❑	❑	❑	❑	❑	❑	❑
Panic Disorder	❑	❑	❑	❑	❑	❑	❑
Personality Disorder	❑	❑	❑	❑	❑	❑	❑
PTSD	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Social Phobia	❑	❑	❑	❑	❑	❑	❑
Septicemia	❑	❑	❑	❑	❑	❑	❑
Stroke/Brain Attack	❑	❑	❑	❑	❑	❑	❑
Sudden Infant Death Syndrome	❑	❑	❑	❑	❑	❑	❑

PATIENT HISTORY

Please describe your past accidents:

1.Accident: _____❑Job ❑Auto ❑Other Date: _____
2.Accident: _____❑Job ❑Auto ❑Other Date: _____
3.Accident: _____❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disk	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_____	❑

SYMPTOMS			
On the following pages you will be asked to choose your symptoms from this list.			
Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain
Other: Please List			

IMPAIRED ACTIVITIES			
To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.			
Computer Use (extended)	Computer Use (Short time)	Concentrating	Cycling
Desk Work	Drawing	Driving	Exercise
Lying Down	Piano	Reading	Running
Sitting	Standing	Staying Asleep	Using the Phone
Walking	Yard Work	Bathing	Bending
Caring for Infirm Person	Cervical Range of Motion	Child Care	Climbing Stair
Falling Asleep	Dressing	Golf	Hair Care
Kneeling	Lifting	Lifting Children	Lifting/Carrying Groceries
Looking over Shoulder	Lying Down	Needlework	Pet Care

SYMPTOMS

Please fill out the form below to describe your current symptoms.

SYMPTOM

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:

❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

Pain Frequency:

❑Constant
❑Frequent
❑Intermittent
❑Occasional

Pain radiates into:

❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other: _____

Pain Cause:

❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

Pain Pattern:

❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

What has been done before to treat this symptom?

❑Acupuncture
❑Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

Date Started:_____

Pain Duration:

❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

Pain aggravated by:

❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

Pain relieved by:

❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

For Doctor's Use Only:

What restrictions relate to the main impaired activity for this symptom?