



PATIENT # _____ DATE: _____ OFFICE USE ONLY
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**-----CONFIDENTIAL PATIENT INFORMATION-----**

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help, please ask the receptionist.

**PATIENT DATA**

(First name, middle initial, last name)      SOCIAL SECURITY # \_\_\_\_\_      DRIVER'S LICENSE# \_\_\_\_\_

NAME \_\_\_\_\_      PHONE- HOME \_\_\_\_\_      EMERGENCY \_\_\_\_\_

CELL PHONE: \_\_\_\_\_      WORK: \_\_\_\_\_      E-MAIL \_\_\_\_\_ @ \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_      CITY \_\_\_\_\_      ZIP CODE \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_      CITY \_\_\_\_\_      ZIP CODE \_\_\_\_\_

AGE \_\_\_\_\_      BIRTHDATE \_\_\_\_\_      MARITAL: M S W D      HOW MANY CHILDREN? \_\_\_\_\_

OCCUPATION \_\_\_\_\_      EMPLOYER \_\_\_\_\_

NAME OF SPOUSE OR PARENT (CIRCLE ONE) \_\_\_\_\_      OFFICE PHONE \_\_\_\_\_      Ext. \_\_\_\_\_

SPOUSE OR PARENTS' EMPLOYER \_\_\_\_\_      OCCUPATION \_\_\_\_\_

PATIENT'S NEAREST RELATIVE (OTHER THAN SPOUSE) \_\_\_\_\_      RELATIONSHIP \_\_\_\_\_

RELATIVE'S ADDRESS \_\_\_\_\_      CITY \_\_\_\_\_      ZIP CODE \_\_\_\_\_

HOW WHERE YOU REFERRED TO OUR OFFICE? \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

WHAT OPERATIONS HAVE YOU HAD? \_\_\_\_\_      WHEN? \_\_\_\_\_

SERIOUS ILLNESSES \_\_\_\_\_

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? \_\_\_\_\_

Briefly describe symptoms you are presently suffering from: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date symptoms appeared \_\_\_\_\_      Have you lost any days work? From: \_\_\_\_\_      To: \_\_\_\_\_

Other doctors seen for this/these condition(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature \_\_\_\_\_      Date \_\_\_\_\_

Guardian or Spouses's  
Signature Authorizing Care \_\_\_\_\_      Date \_\_\_\_\_

Information Taken By: \_\_\_\_\_      Date: \_\_\_\_\_

**-PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO-**

**HEALTH QUESTIONNAIRE: CHECK ANY OF THE FOLLOWING SYMPTOMS YOU ARE PRESENTLY HAVING.**

**SYMPTOMS**

**HEAD:**

- Headache
- Entire head
- Back of head
- Forehead
- Temples
- Migraine
- Loss of balance
- Dizziness
- Ringing in ears

**NECK:**

- Stiff neck
- Muscle spasms in neck
- Grinding sounds in neck
- Pain in neck
- Neck pain with movement

**SHOULDERS**

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
- Above shoulder level
- Above head
- Tension in shoulders

**ARMS & HANDS**

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins & needles in arms
- Sensation of pins & needles in fingers
- Fingers go to sleep
- Hands cold
- Loss of grip strength

**MID-BACK:**

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing pain in mid-back.
- Muscle spasms

**LOW BACK:**

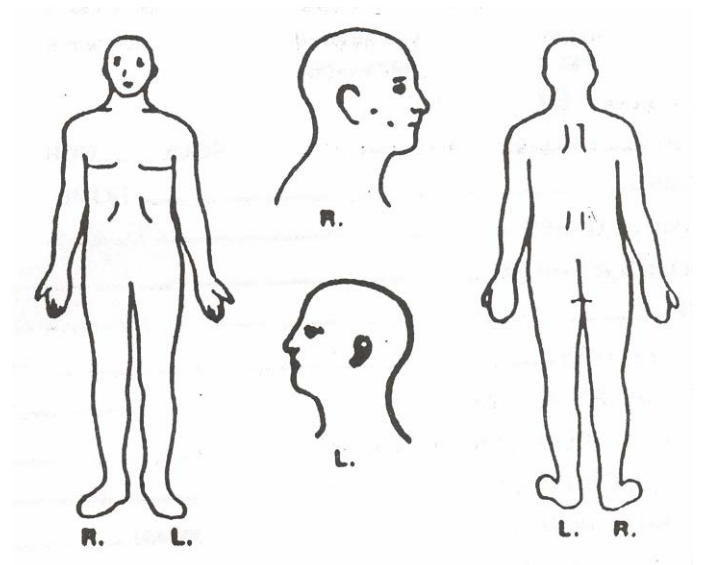
- Low back pain
- Low back pain is worse when:
  - Working
  - Lifting
  - Stooping
  - Standing
  - Bending
  - Coughing
- Low back feels out of place
- Muscle spasm
- Arthritis

**HIPS, LEGS & FEET:**

- Pain in buttocks (R-L)
- Pain in hip joint (R-L)
- Pain down leg (R-L)
- Pain down both legs
- Leg cramps
- Pins & needles in legs (R-L)
- Numbness of leg (R-L)
- Numbness of feet (R-L)
- Numbness of toes
- Feet feel cold
- Cramps in feet (R-L)
- Swollen ankles (R-L)
- Swollen feet (R-L)

Mark Areas of Pain In RED

Mark areas of tingling/Numbness in Blue



**CHEST**

- Chest pain
- Shortness of breath
- Pain around ribs

**GENERAL:**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run down
- Loss of sleep
- Loss of weight

**ABDOMEN:**

- Nervous stomach
- Nauseas
- Gas
- Constipation
- Diarrhea

**FEMALES:**

Date of last menses \_\_\_\_\_

Are you pregnant?

- Yes  No

**\* DO NOT WRITE BELOW THIS LINE \***

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FX. \_\_\_\_\_

Prior Acc. \_\_\_\_\_

D.C.'s \_\_\_\_\_

Patient accepted?  Yes  No Doctor's signature: \_\_\_\_\_