PATIENT INFORMATION

NAME____ D.O.B.:__________________________ SEX________

(Medicare/Medicaid only) S.S #: ________-_______-_________

ADDRESS____CITY__________________________STATE______ZIP________

HOME PHONE_____________________ CELL PHONE_________________________ WORK PHONE___________________

PLACE OF EMPLOYMENT________________________________OCCUPATION____________________________________

EMAIL ____

REASON FOR OFFICE VISIT:____

AREA OF COMPLAINT:____

WHEN DID THIS BEGIN?____

HOW DID THIS HAPPEN/WHAT WERE YOU DOING?____

IF PAIN, DESCRIBE (CIRCLE): SHARP, DULL/ACHY, VARRYING, TRAVELS, CONSTANT

RATE THE PAIN 0-10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN YOU COULD IMAGINE:____________

SINCE THE PROBLEM STARTED, IS IT: (CIRCLE) ABOUT THE SAME, GETTING BETTER, GETTING WORSE

WHAT MAKES IT WORSE:__________________________________ BETTER:______________________________________

IT INTERFERES WITH: (CIRCLE) WORK, SLEEP, WALKING, HOBBIES/SPORTS, OTHER:_________________________

OTHER DOCTORS SEEN FOR THIS PROBLEM:____

TREATMENT(S) RENDERED?____ OUTCOME?___________

HAVE YOU HAD X-RAYS, MRI, OR A CT?____________________

CURRENT HEALTH PROBLEMS/CONCERNS:____

____

____

MEDICATIONS:____

____

____

CURRENT SUPPLEMENTS:____

____

____

MAJOR HOSPITALIZATIONS/SURGERIES/INJURIES, (INCLUDE YEAR AND OUTCOME)

____

____

____

PLEASE CHECK ALL THAT APPLY:

☐ UNINTENTIONAL WEIGHT LOSS/GAIN OF 10 LBS. OR MORE IN THE LAST THREE MONTHS

☐ FATIGUE	☐ DOUBLE/BLURRED VISION	☐ RINGING IN EARS	☐ NAUSEA
☐ WEAKNESS	☐ EARACHES	☐ HEAD INJURY	☐ HEADACHES
☐ COUGH	☐ ASTHMA	☐ EMPHYSEMA	☐ HEARTBURN
☐ DIZZINESS	☐ HIGH BLOOD PRESSURE	☐ FAINTING	☐ SEIZURES
☐ BLEEDING GUMS	☐ HEARING PROBLEMS	☐ HEART TROUBLE	☐ ARTHRITIS
☐ CONSTIPATION	☐ DIARRHEA	☐ MUSCLE/JOINT PAIN	☐ STIFFNESS
☐ NUMBNESS	☐ LOSS OF SENSATION	☐ TREMORS	☐ DIABETES
☐ DEPRESSION	☐ MEMORY LOSS	☐ MOOD CHANGES	☐ NERVOUSNESS

FAMILY HEALTH HISTORY: (PLEASE INDICATE WHICH FAMILY MEMBER)

☐ ARTHRITIS ____

☐ ASTHMA ____

☐ ALCOHOLISM/DRUG ABUSE ____

☐ ALZHEIMER'S ____

☐ CANCER (TYPE)____

☐ DEPRESSION____

☐ DIABETES____

☐ HEART DISEASE____

☐ STROKE____

☐ OTHER____

HEALTH HABITS (PER DAY)

☐ TOBACCO ________________________________

☐ ALCOHOL ________________________________

☐ CAFFEINE (COFFEE/TEA/SODA) ______________

☐ WATER __________________________________

EXERCISE: ☐ 5-7 DAYS/WK ☐ 3-4 DAYS/WK ☐ 1-2 DAYS/WK ☐ NONE

TYPE:____