CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name _____

Cell _____ Home _____ Work _____

Email _____ Please check if you do not want to be contacted by email ☐

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Marital Status _____ Sex _____ No of children _____

Soc Sec # _____ Occupation _____ Employed by _____

Spouse's Name _____ Date of Birth _____ Soc Sec # _____

Spouse's Employer _____

Name of Nearest Relative _____ Phone # _____

Is This Condition Related To: Employment __Yes __No Automobile Accident __Yes __No

Other: _____

Have You Had in An Accident in the Past: (Circle one) Year 5 years Over 5 Years

Please check the boxes that apply to you O= OCCAISIONAL F=FREQUENT C=CONSTANT

O	F	C	General Symptoms
☐	☐	☐	ALLEREGIES
☐	☐	☐	CONVULSIONS
☐	☐	☐	DIZZINESS
☐	☐	☐	FAINTING
☐	☐	☐	FATIGUE
☐	☐	☐	FEVER
☐	☐	☐	HEADACHE
☐	☐	☐	LOSS OF SLEEP
☐	☐	☐	NUMBNESS
☐	☐	☐	TREMORS
☐	☐	☐	SWOLLEN JOINTS
☐ Y	☐ N		ARE YOU PREGNANT?

O	F	C	Muscle and Joints
☐	☐	☐	ARTHRITIS
☐	☐	☐	BURSITIS
☐	☐	☐	TENDONITIS
☐	☐	☐	FOOT PAIN
☐	☐	☐	LOW BACK PAIN
☐	☐	☐	NECK PAIN OR STIFFNESS
☐	☐	☐	PAIN IN THE SHOULDERS
☐	☐	☐	UPPER BACK PAIN
☐	☐	☐	PAIN IN THE SIDES

O	F	C	Pain or Numbness In:
☐	☐	☐	SHOULDERS
☐	☐	☐	ARMS
☐	☐	☐	ELBOWS
☐	☐	☐	HANDS
☐	☐	☐	LEGS
☐	☐	☐	KNEES
☐	☐	☐	FEET
☐	☐	☐	PAINFUL TAILBONE
☐	☐	☐	POOR POSTURE

Check the Conditions You Have Had:

☐ ALCOHOLISM	☐ DIABETES	☐ LUMBAGO	☐ CANCER
☐ ANEMIA	☐ EPILEPSY	☐ VENEREAL DISEASE	☐ GOUT

What is your major complaint? _____

_____

Other complaints? _____

How long have you had it? _____

Is it getting worse? __Yes __No Contstant Pain? _____

How long has it been since you felt good? _____

What do you believe is wrong? _____

Describe any surgeries. _____

Have been treated by a physician for anything this last year? _____

Date of last physical exam? _____

Are you allergic to any medication? _____

Are you taking any medication? _____

I authorize the release of any medical information necessary to process claims.
A photocopy of this release is as valid as the original.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____