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 the form. If you need any help, please ask the receptionist.

______________________________ DATE

IS YOUR VISIT DUE TO AN ACCIDENT YES NO (IF YES, PLEASE COMPLETE BOTH SIDES)

PATIENT DATA

WORK PHONE (____) ____________________

NAME ____ HOME PHONE (____) ____________________

CELL PHONE (____) ____________________

E-MAIL ______________________________

ADDRESS ______________________________ CITY ____________________ STATE __________ ZIP ______

AGE ______ BIRTH DATE ________________ MARITAL STATUS __________ NUMBER OF CHILDREN ________

OCCUPATION ____________________ EMPLOYED BY ______________________ SS #__________________

NAME OF NEAREST RELATIVE ______________________________ PHONE NUMBER (___) ______________

NAME OF WIFE OR HUSBAND ______________________________ OCCUPATION ______________________

EMPLOYER ____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS ____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION ______________________________

MEDICAL HISTORY (If any of the following are relevant to your medical history please √ the accompanying box.)

CANCER	MUSCULAR DYSTROPHY	RHEUMATIC FEVER
POLIO	MULTIPLE SCLEROSIS	SCARLET FEVER
TUBERCULOIS	CONVULSIONS	NERVOUSNESS
HIGH BLOOD PRESSURE	EPILESPY	ASTHMA
HEART TROUBLE	CONCUSSION	DIGESTIVE DISORDERS
DIABETES	DIZZINESS	SINUS TROUBLE
HEPATITIS	ARTHIRITIS	BACKACHES
GERMAN MEASLES	NEURITIS	NUMBNESS
VENERAL DISEASE	RHEUMATISM	ANEMIA

DESCRIBE THE OPERATIONS YOU HAVE HAD: ______________________________ WHEN? ______________

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? YES NO

DESCRIBE CONDITION ______________________________ DATE OF LAST PHYSICAL EXAM ____________

ARE YOU ON ANY MEDICATIONS EITHER PRSCRIPTION OR OVER THE COUNTER? ? YES NO IF YES, WHAT KIND?

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ARE YOU ALLERGIC TO ANY MEDICATION? YES NO IF YES, WHAT KIND? ______________________________

ARE YOUR PREGNANT? YES NO DATE OF LAST MENSTRUAL PERIOD ______________________________

INSURANCE DATA (Clinic policy requires payment arrangements be made on the first visit)

DO YOU HAVE INSURANCE? YES NO COMPANY ______________________________

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE ____

SPOUSE'S INSURANCE ______________________________ ______________________________

DO YOU HAVE A HEALTH SAVINGS ACCOUNT (HSA)? YES NO

DO YOU HAVE A FLEXIBLE SPENDING ARRANGEMENT (FSA) ? YES NO

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE ______________________________ DATE ______________

SPOUSE'S OR GUARDIAN'S SIGNATURE DATE

ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT_______________________________ HOUR OF ACCIDENT ____________AM PM

TYPE OF ACCIDENT: WORK RELATED TRAFFIC OTHER

WORK RELATED ACCIDENT
WAS ANY EQUIPMENT, MACHINERY, AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? ____________________

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER: YES NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? YES NO

TRAFFICENT ACCIDENT
WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? TRUCK CAR MOTORCYCLE OTHER

WERE YOU DRIVER PASSENGER PEDESTRIAN?

I F A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE CAR. ____________________

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? YES NO MPH? ____________________

DID YOUR VEHICLE HIT OTHER VEHICLE(S)? YES NO WHERE? ____________________

DID OTHER VEHICLE(S) HIT YOUR VEHICLE? YES NO WHERE? ____________________

WAS THE ACCIDENT REPORTED TO THE POLICE DEPARTMENT YES NO

WERE TRAFFIC CITATIONS ISSUED? YES NO TO WHOM? ____________________

DESCRIBE THE ACCIDENT INCLUDING CAUSE(S) AND SURROUNDING CIRCUMSTANCES ____________________

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PRESENT COMPLAINT

HEADACHE
HEAD SEEMS TOO HEAVY
HEAD & SHOULDER TIRED & HEAVY
MENTAL DULLNESS
LOSS OF MEMORY
EQUILIBRIUM PROBLEMS
DIZZINESS
FAINTING
TREMORS
PALPITATION
NECK PAIN
NECK STIFFNESS
NECK MOTION RESTRICTED
UPPER BACK PAIN/STIFFNESS
MID BACK PAIN/STIFFNESS
LOW BACK PAIN/STIFFNESS

PINS & NEEDLES IN ARMS/LEGS
NUMBNESS IN FRINGERS, ARMS, LEGS
CHEST PAIN
SHORTNESS OF BREATH
EYE STRAIN
PAIN BEHIND EYES
EYES SENSITIVE TO LIGHT
EYES LOSS OF FOCUS
DOUBLE VISION
EARS BUZZING/RINGING
LOSS OF TASTE
LOSS OF SMELL
SINUS TROUBLE
EXTREME NERVOUSNESS
TENSION
IRRITABILITY

ANXIETY
EXTREME FATIGUE
INSOMNIA
NEURITIS
FACE FLUSHED
FACE PALE
EXCESS PERSPIRATION
DIGESTIVE DISORDERS
NAUSEA, VOMITING
DIARRHEA
CONSTIPATION
DEPRESSION
SWOLLEN ____________
FEET/HANDS COLD
DIFFICULTY IN PROLONGED CAR RIDING

DIFFICULTY IN EXCESSIVE STANDING WALKING RIDING BENDING
NECK, LOW BACK PAIN & STIFFNESS UPON RISING
PAIN RADIATING INTO NECK BASE OF SKULL SHOULDER ARMS HIPS LEGS
DID YOU REQUIRE POST: ACCIDENT HOSPITALIZATION? YES NO IF SO, WHERE?____________________
HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? YES NO

SYMPTOMS OTHER THAN ABOVE ____

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