PATIENT INFORMATION

Patient #____________

PERSONAL INFORMATION:

Title ___ Last Name ___ First Name ___ M.I. ___ Nickname (if any) ___

Street Address ___ City ___ State ___ Zip Code ___

Home Phone ___ Mobile Phone ___ Email Address ___

Social Security Number ___ Driver's License Number ___ Birth Date ___ Age ___

Sex ___ Weight ___ Height ___ No. of Children ___ Date of first visit ___ Referred by ___

WORK INFORMATION:

Occupation ___ Employer ___ Work Phone Number ___

Employer's Street Address ___ City ___ State ___ Zip Code ___

SPOUSE INFORMATION: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner

Spouse's Last Name ___ Spouse's First Name ___ Spouse's Social Security Number ___

Occupation ___ Employer ___ Work Phone Number ___

MEDICAL INFORMATION:

Date of Injury ___ Place of Injury ___ Major Complaint ___

What activities aggravate your condition? ____

How long have you had this condition? ___________________ How long has it been since you really felt good? ___________

List surgical operations____

List any medications you are currently taking____

Other doctors seen for this condition ☐ MD ☐ DC ☐ DO ☐ DDS ___ Doctor's name

Length of time under care ___ X-rays taken ___ Other ___

OVER→

Please check all appropriate symptoms:

HEAD:
- ☐ Headache
- ☐ Sinuses
- ☐ Memory loss
- ☐ Light bothers eyes
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

NECK:
- ☐ Neck pain

SHOULDERS:
- ☐ Shoulder pain- R L

ARMS & HANDS:
- ☐ Pain in arms
- ☐ Fingers go to sleep

MID BACK:
- ☐ Mid back pain
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath

ABDOMEN:
- ☐ Nervous stomach

LOW BACK:
- ☐ Low back pain
- ☐ Pain in buttocks- R L
- ☐ Pain down leg- R L

WOMEN ONLY:
- ☐ Menopause
- ☐ Birth control- type:________

GENERAL:
- ☐ Weight loss:___________lbs
- ☐ Weight gain:__________lbs.
- ☐ Cigarettes:________pack/day

Mark the areas on your body where you feel the described sensations, using the appropriate symbol. Mark areas of radiation. Include all afflicted areas.

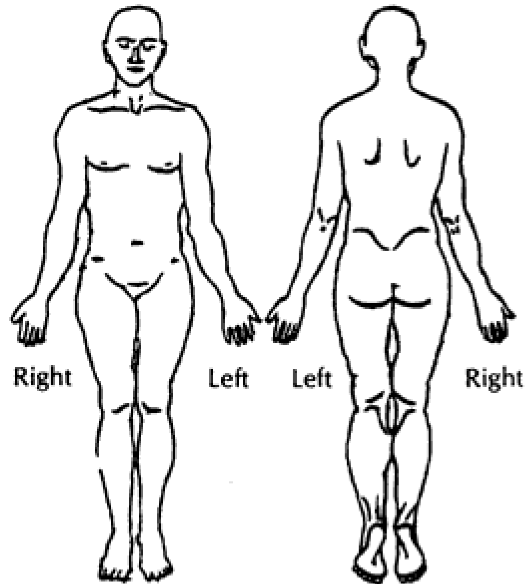
XXXXX
XXXXX NUMBNESS
XXXXX

OOOOO
OOOOO PINS & NEEDLES
OOOOO

+ + + + +
+ + + + + BURNING
+ + + + +

/////
///// STABBING
/////

^ ^ ^ ^ ^
^ ^ ^ ^ ^ ACHING
^ ^ ^ ^ ^



RESPONSIBLE INFORMATION:

Who is responsible for this account? ☐ Self ☐ Attorney ☐ Other:___________________________________
If not yourself, please provide the following information:

_______________________ _______________________ _______________________
Last Name | First Name | Phone Number

_______________________ _______________________ _______ _______________
Street Address | City | State | Zip Code

_______________________ _______________________
Social Security Number | Employer

I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Patient's Signature____ Date______________________

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