

# 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.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CANCER              | <input type="checkbox"/> MUSCULAR DYSTROPHY | <input type="checkbox"/> RHEUMATIC FEVER     |
| <input type="checkbox"/> POLIO               | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> SCARLET FEVER       |
| <input type="checkbox"/> TUBERCULOSIS        | <input type="checkbox"/> CONVULSIONS        | <input type="checkbox"/> NERVOUSNESS         |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EPILEPSY           | <input type="checkbox"/> ASTHMA              |
| <input type="checkbox"/> HEART TROUBLE       | <input type="checkbox"/> CONCUSSION         | <input type="checkbox"/> DIGESTIVE DISORDERS |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> DIZZINESS          | <input type="checkbox"/> SINUS TROUBLE       |
| <input type="checkbox"/> HEPATITIS           | <input type="checkbox"/> ARTHRITIS          | <input type="checkbox"/> BACKACHES           |
| <input type="checkbox"/> GERMAN MEASLES      | <input type="checkbox"/> NEURITIS           | <input type="checkbox"/> NUMBNESS            |
| <input type="checkbox"/> VENEREAL DISEASE    | <input type="checkbox"/> RHEUMATISM         | <input type="checkbox"/> 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 \_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN \_\_\_\_\_ NAME OF CLINIC \_\_\_\_\_

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

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

WOMEN- ARE YOU PREGNANT?  YES  NO DATE OF LAST MENSTRUAL PERIOD? \_\_\_\_\_

FAMILY HISTORY OF BACKTROUBLE, HEADACHES, SCOLIOSIS, PINCHED NERVES ? \_\_\_\_\_

## 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 \_\_\_\_\_

# 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

## TRAFFIC ACCIDENT

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

WERE YOU  DRIVER  PASSENGER  PEDESTRIAN?

IF 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 \_\_\_\_\_

## PRESENT COMPLAINT

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> HEADACHE                      | <input type="checkbox"/> PINS & NEEDLES IN ARMS/LEGS    | <input type="checkbox"/> ANXIETY                 |
| <input type="checkbox"/> HEAD SEEMS TOO HEAVY          | <input type="checkbox"/> NUMBNESS IN FINGERS, ARMS,LEGS | <input type="checkbox"/> EXTREME FATIGUE         |
| <input type="checkbox"/> HEAD & SHOULDER TIRED & HEAVY | <input type="checkbox"/> CHEST PAIN                     | <input type="checkbox"/> INSOMNIA                |
| <input type="checkbox"/> MENTAL DULLNESS               | <input type="checkbox"/> SHORTNESS OF BREATH            | <input type="checkbox"/> NEURITIS                |
| <input type="checkbox"/> LOSS OF MEMORY                | <input type="checkbox"/> EYE STRAIN                     | <input type="checkbox"/> FACE FLUSHED            |
| <input type="checkbox"/> EQUILIBRIUM PROBLEMS          | <input type="checkbox"/> PAIN BEHIND EYES               | <input type="checkbox"/> FACE PALE               |
| <input type="checkbox"/> DIZZINESS                     | <input type="checkbox"/> EYES SENSITIVE TO LIGHT        | <input type="checkbox"/> EXCESS PERSPIRATION     |
| <input type="checkbox"/> FAINTING                      | <input type="checkbox"/> EYES LOSS OF FOCUS             | <input type="checkbox"/> DIGESTIVE DISORDERS     |
| <input type="checkbox"/> TREMORS                       | <input type="checkbox"/> DOUBLE VISION                  | <input type="checkbox"/> NAUSEA, VOMITING        |
| <input type="checkbox"/> PALPITATION                   | <input type="checkbox"/> EARS BUZZING/RINGING           | <input type="checkbox"/> DIARRHEA                |
| <input type="checkbox"/> NECK PAIN                     | <input type="checkbox"/> LOSS OF TASTE                  | <input type="checkbox"/> CONSTIPATION            |
| <input type="checkbox"/> NECK STIFFNESS                | <input type="checkbox"/> LOSS OF SMELL                  | <input type="checkbox"/> DEPRESSION              |
| <input type="checkbox"/> NECK MOTION RESTRICTED        | <input type="checkbox"/> SINUS TROUBLE                  | <input type="checkbox"/> SWOLLEN _____           |
| <input type="checkbox"/> UPPER BACK PAIN/STIFFNESS     | <input type="checkbox"/> EXTREME NERVOUSNESS            | <input type="checkbox"/> FEET/HANDS COLD         |
| <input type="checkbox"/> MID BACK PAIN/STIFFNESS       | <input type="checkbox"/> TENSION                        | <input type="checkbox"/> DIFFICULTY IN PROLONGED |
| <input type="checkbox"/> LOW BACK PAIN/STIFFNESS       | <input type="checkbox"/> IRRITABILITY                   | <input type="checkbox"/> 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 \_\_\_\_\_