

# Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT 928.474.9355 (WELL)



## PATIENT INFORMATION

Today's Date:

Name:   Male  Female

Mailing Address:  City:  State:  Zip:

Home Phone:  Work Phone:  EXT:

Social Security #:  Age:  Date of Birth:

Marital Status:  Married  Single  Divorced  Separated  Other

Name of Spouse or Nearest Relative:  Phone:

Referred to this Office By:

- Friend/Family Member - Name?
- Yellow Pages  Mail
- Clinic Location  Web Site  Other

Your Occupation:  Your Employer:

Payment for services will be by:

- Cash  Check  Credit Card  Health Insurance
- Automobile Insurance  Worker's Compensation

Name of Insurance Co.:  Group #:  Phone:

Insured's ID #:  Insured's Date of Birth:

Are you covered by more than one insurance company?  No  Yes-Name



## MEDICAL/FAMILY HISTORY

**S=SELF M=MOTHER  
F=FATHER**

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury

- convulsions
- diabetes
- indigestion
- menstrual cramps
- multiple sclerosis
- muscular dystrophy
- sinus trouble
- tuberculosis
- other

Have you been treated by a physician for any health condition in the past year?  Yes  No

Describe condition:  Date of Last Physical Exam:

**SURGICAL HISTORY:**

1.  Date:
2.  Date:
3.  Date:

Have you ever had a metal implant?  Yes  No

Have you ever been gunshot?  Yes  No

**ACCIDENT HISTORY:**

- Explanation:  Date:  Job  Auto  Other
- Explanation:  Date:  Job  Auto  Other
- Explanation:  Date:  Job  Auto  Other

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS**

Please Rate Your Symptoms (1-10 with 1 being least serious)

1.  Rating
2.  Rating
3.  Rating

Symptoms are worse in the  Morning  Afternoon  Night

When and how occurred?

Symptoms developed from:  Job Related Injury  Auto Accident  Accident  Other  Illness  Unknown Cause  Gradual Onset - **Date Occured**

Symptoms have persisted for #  Hour(s)  Day(s)  Week(s)  Month(s)  Year(s)

Symptoms/Complaints:  Come & Go  Are Constant

Have your ever had this before:  No  Yes - When?

If you were to guess, what do you think is causing your complaints?

Name and location of doctors previously seen for present condition(s):

Are you allergic to any medications:  No  Yes - What Kind?

Are you taking any medications:  No  Yes - What Kind?

Are you pregnant:  No  Yes - Date of last menstrual period:

Please check the following activities the **aggravate** your condition:

- Bending  Reaching  Straining at Stool  Coughing  Sitting  Turning Head  
 Lifting  Sneezing  Walking  Lying Down  Standing

Please check the following activities that **relieve** your condition:

- Bending  Sitting  Lifting  Standing  Lying Down  Turning Head  
 Reaching  Walking

Please check any **additional symptoms** you may be experiencing:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> blurred vision          | <input type="checkbox"/> buzzing in ears           | <input type="checkbox"/> cold feet                        |
| <input type="checkbox"/> cold hands              | <input type="checkbox"/> cold sweats               | <input type="checkbox"/> concentration loss/<br>confusion |
| <input type="checkbox"/> constipation            | <input type="checkbox"/> depression/weeping spells | <input type="checkbox"/> diarrhea                         |
| <input type="checkbox"/> dizziness               | <input type="checkbox"/> face flushed              | <input type="checkbox"/> fainting                         |
| <input type="checkbox"/> fatigue                 | <input type="checkbox"/> fever                     | <input type="checkbox"/> head seems too heavy             |
| <input type="checkbox"/> headaches               | <input type="checkbox"/> insomnia                  | <input type="checkbox"/> light bothers eyes               |
| <input type="checkbox"/> loss of balance         | <input type="checkbox"/> loss of smell             | <input type="checkbox"/> loss of taste                    |
| <input type="checkbox"/> low resistance to colds | <input type="checkbox"/> muscle jerking            | <input type="checkbox"/> numbness in fingers              |
| <input type="checkbox"/> numbness in toes        | <input type="checkbox"/> pins and needles in arms  | <input type="checkbox"/> pins and needles in legs         |
| <input type="checkbox"/> ringing in ears         | <input type="checkbox"/> shortness of breath       | <input type="checkbox"/> stiff neck                       |
| <input type="checkbox"/> stomach upset           |  |   |

How often are your symptoms present? **select**