

PATIENT FILE# _____ DATE: ___ / ___ / ___

PATIENT INTRODUCTION

**All information on this form is required and must be filled out completely before you can be seen
this, is our office policy
DO NOT LEAVE ANY BLANK SPACES**

APPLICABLE FEES ARE PAYABLE WHEN SERVICES ARE RENDERED

Full Legal Name _____ Nick Name: _____
Street Address _____ PO Box# _____ Apt# _____
City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell phone _____ - _____ - _____
E-mail Address _____ (to receive Clinic Newsletter) Sex M F Marital Status S M D W
Birth Date ___ / ___ / ___ Age _____ SS# _____ - _____ - _____

Place of Employment _____
Address _____

When Hired ___ / ___ / ___ Shift 1 2 3

Name of closest relative **not living with you** _____ Relation _____

Street Address _____ PO Box # _____

City _____ State _____ Zip _____

Phone _____ - _____ - _____

Is this accident related: Yes No Auto Home Work Date of accident ___ / ___ / ___

Attorney _____

ASK FOR AN *ACCIDENT REPORT FORM* IF THESE SYMPTOMS COULD BE THE RESULT OF AN ACCIDENT

How did you hear about our clinic? _____

BILLING AND INSURANCE INFORMATION

(IF PATIENT IS A MINOR-GUARANTOR MUST COMPLETE)

Relation to insured: Self Spouse Child Other _____

If insured is "self" please complete ANY information NOT listed above.

If insured is other than "self", please complete ALL information below.

Insured's full name: _____ Birthdate ___ / ___ / ___

Insured's SSN: _____ - _____ - _____ Home phone _____ - _____ - _____

Street Address _____ PO Box # _____ Apt # _____

City _____ State _____ Zip _____

Insurance Company _____ Verification phone _____ - _____ - _____

Group Number _____ Insured's ID Number _____

Employer _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Shift 1 2 3

Street Address _____

City _____ State _____ Zip _____

ADDITIONAL COVERAGE:

Relation to insured: Self Spouse Child Other _____

Insured's Full Name _____ Shift 1 2 3

Ins. Co. Name _____

Social Security Number _____ - _____ - _____ Birthdate ___ / ___ / ___

Street Address _____ PO Box # _____ Apt. # _____

City _____ State _____ Zip _____

Employer _____ When Hired ___ / ___ / ___

Address _____ City _____ State _____ Zip _____


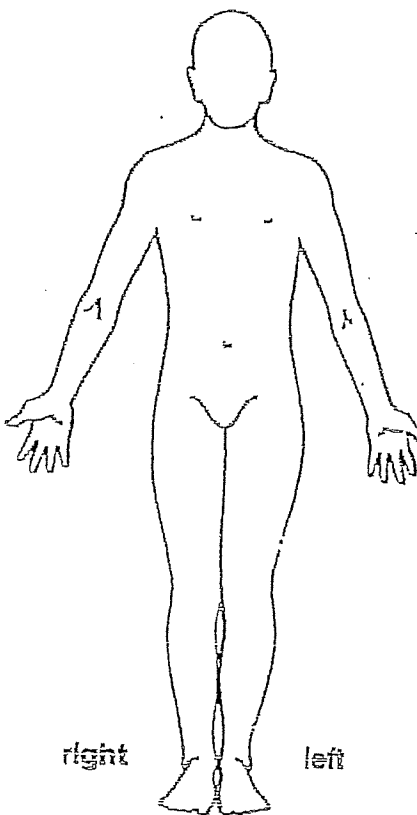
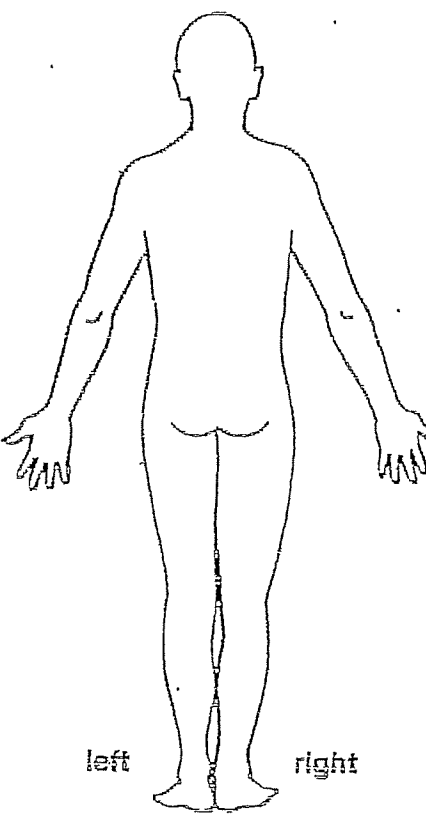

Verification Phone _____ - _____ - _____ Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

PAIN CHART

Name: _____ Account #: _____

Please describe your condition: _____

Please mark area(s) of injury or discomfort using the appropriate symbols.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
-----	00000		^^^^^	XXXXX
				
	right	left	left	right
	Front		Back	

Circle One: Sharp Dull Circle One: Moderate Mild Severe

Doctor's Notes: _____

Patient's Signature: _____ Date: _____

PATIENT CONSULTATION

DATE _____ ACCT # _____ REFERRAL SOURCE _____

NAME _____ DOB _____ AGE _____

OCCUPATION _____ MARITAL STATUS S M D N

CC: _____

M F POSSIBLE PREGNANCY DATE OF LAST OB/GYN EXAM _____ HT: _____ WT: _____

PROSTHETICS _____ IMPLANTS _____ SMOKER _____ WATER _____ ALCOHOL _____ CAFFIENE _____

HEART DX HBP OSTEOPOROSIS CANCER STROKE DIABETES OTHER _____

GUM DX DENTAL/ORAL PROBLEMS LAST DENTAL EXAMINATION _____

EYE / VISUAL DX _____ LAST EYE EXAMINATION _____

Primary Care Physician Name: _____ Date last visit _____ Date of most recent Lab test _____

SERIOUS ILLNESSES _____

SURGERIES _____

HOSPITALIZATIONS _____

TRAUMAS _____

ACCIDENTS _____

CHIEF COMPLAINTS

WHEN WAS THIS PROBLEM FIRST NOTICED? _____

HAVE YOU HAD THIS PROBLEM BEFORE? YES NO HOW OFTEN? _____

WORSE/BETTER AM PM EXPLAIN _____

DOES ANY POSITION RELIEVE THE PROBLEM? _____

EXACT LOCATION _____

FREQUENCY _____ DURATION _____

OTHER DOCTORS SEEN FOR THIS PROBLEM _____

WAS SURGERY RECOMMENDED? YES NO WHO _____

MEDICATION RECOMMENDED? YES NO WHO _____

FAMILY HISTORY

HEART DX HBP OSTEOPOROSIS CANCER STROKE DIABETES OTHER _____

FATHER _____

MOTHER _____

SIBLINGS _____

DATE

PT'S NAME

ACCOUNT#

GENERAL SYMPTOMS

<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	HEADACHES.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	DIZZINESS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	BLURRED VISION.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	CONCENTRATION LOSS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	DEPRESSION.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	NERVOUSNESS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	DIFF. SLEEP.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	LOSS ENERGY.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	TIRED/MORNINGS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	BUZZ/RING EARS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	RUN DOWN.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	FAINING.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	PALPITATIONS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	BREATHING PROBLEMS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	ENT.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	FREQ. _____	DUR _____

GENERAL PROBLEMS WITH FOLLOWING

VERBAL PAIN LEVEL SCALE: 1=MILD 5=MODERATE 10=WORSE PAIN EVER

<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	HEAD.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	SINUSES.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	NECK PAIN/STIFF.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	SHOULDER PROBS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	UPPER BACK.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	MID BACK.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	CHEST PAIN.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	LUNG.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	HEART/HBP.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	STOMACH.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	INDIGESTION.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	BLADDER.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	LIVER.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	KIDNEY.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	COLON.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	CONSTIPATION/DIARRHEA...	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	LOW BACK.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	HIP.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	LEG PAIN/CRAMPS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	POOR CIRCULATION.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	BLOOD, HEPATITIS, HIV.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	MONONUCLEOSIS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
<input type="checkbox"/> NOW	<input type="checkbox"/> EVER	OTHER.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____

GENERAL PROBLEMS WITH FOLLOWING

HOSPITAL/SURGERY.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
ACCIDENTS/FALLS/AUTO.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
ACCIDENTS/JOBS.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
ANY MEDICATION.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____
MOTHER, FATHER, SIBLINGS BACK PROBLEMS...	<input type="checkbox"/> YES	<input type="checkbox"/> NO.....	EXP. _____

REVIEWER'S NOTES
