

CONFIDENTIAL PATIENT INFORMATION

Case No. _____

Name _____ SS# _____ Home Phone _____

Address _____ City _____ Zip Code _____

Email address _____

Age _____ Sex: M F Birth Date _____ Marital Status: M S W D How many children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Spouse _____ Birth Date: _____ SS# _____

Employer _____ Occupation: _____ Office Phone _____

Patient's Nearest Relative _____ Phone _____

Referred By _____ Family Doctor _____

Purpose of this Appointment _____

Is this complaint due to an accident? Yes _____ No _____ Work related? _____ Auto? _____

Other Doctors Seen For This Condition _____

Date of Last Physical Examination _____

What Surgeries Have You Had? _____ When? _____

Serious Illness? _____ When? _____

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

Describe _____

What medications or drugs are you taking? _____

Please put a check by all past conditions and a "C" next to current conditions . . .

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Tension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Face Flush |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Sleeping Problem | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Fever | |

Patient's Signature _____ Date _____