Patient Information

(Please print) Date:______________

Personal Information

Name:(last)________________________(first)____________________(middle) _________________________
Address:______________________________City:______________________State:________Zip:__________
Home phone:_______________Mobile phone:_______________Birth date:_____________Age: ________
E-Mail_______________________________________Height:_______________Weight:________________
Social Security #:____________________________Driver's license #: ______________________________
Employer's Name: ____Work phone: _____________
Employer's Address:_____________________________City:_____________State:________Zip:__________
Referred by:____
Marital Status: M S W D Number of children:______________
Spouse's Name:_____________________________________

History

Present Complaint?____
On the scale below, please circle the intensity of your main complaint at its worst.
None Mild Mild-Moderate Moderate Moderate-Severe Severe
0-----------1-----------2-----------3-----------4-----------5------------6------------7------------8------------9------------10
On the scale below, please circle the percentage of time you experience your main complaint.
None Occasional Intermittent Frequent Constant
0----------10----------20----------30----------40----------50----------60-----------70----------80-----------90----------100
When did this condition begin?____________________
What caused this condition? ____
Have you experienced this condition before? N Y If yes, when was the last time? _______________________
How often do you experience recurrences of this condition? ____
What makes it feel better?____
____
What makes it feel worse?____
____
Please list the dates you were unable to work: ____
Have you seen another doctor for this condition? N Y If yes, who and when?__________________________
____
Have you seen a doctor in the past 2 years? N Y If yes, who, when and for what?______________________
____
____
Have you experienced a sudden significant weight gain? N Y or weight loss? N Y in the past year? If yes,
When? How much? Why?____
Have you sustained serious bodily injury as a result of an accident? N Y If yes, what were the injuries and
approximately when and how were they sustained?____
____
Have you had any broken bones? N Y If yes, which bones? How did it happen? Approximately when did it
happen?____
Have you had any surgeries? N Y If yes, for what and approximately when? ___________________________
____
____
____
Do you have cancer or have you had cancer? N Y If yes, what kind? Approximately when were you diagnosed
and what is your present status?____
____
____

Are you taking prescription medications? N Y If yes, name each medication and why it is being taken ________

____

____

Systems Review

Have you experienced or are you presently experiencing a problem with any of the following body systems?

Eyes, Ears, Nose or Throat problems? N Y If yes, what problem? ______________________________________

____

Musculo-skeletal (muscle, bone or joint) problems? N Y If yes, what problem? ___________________________

____

Nervous system (brain, spinal cord or nerve) problems? N Y If yes, what problem?______________________

____

Cardio-vascular-respiratory (heart, blood, blood vessel or lung) problems? N Y If yes, what problem?

____

____

Gastro-intestinal (stomach, pancreas, liver, gall bladder, small intestine or colon) problems? N Y If yes, what problem? ____

____

Genito-urinary-reproductive (kidney, urinary bladder, uterus, ovaries, prostate, testicles, or external genitalia) problems? N Y If yes, what problem? ____

____

Endocrine (hypothalamus, pituitary, pineal, thyroid, thymus, parathyroid, pancreas, adrenal, ovary or testicle) problems? N Y If yes, what problem? ____

____

Immune (tonsils, lymph nodes, thymus, spleen, bone marrow, white blood cells) problems? N Y If yes, what problem? ____

____

Social History

Do you **exercise**? N Y if yes, ___occasionally ___frequently ___regularly

Do you use **tobacco** products? N Y if yes, what type ________________ and how much/often______________

Do you drink **alcohol** products? N Y if yes, ___socially ___occasionally ___frequently ___regularly

Do you use **non-prescribed drugs**? N Y if yes, what are you using and how much/often__________________

____

Family History

Please indicate if your family members have experienced the following conditions.

	mother	father	maternal grandmother	maternal grandfather	paternal grandmother	paternal grandfather
Heart disease?	___	___	___	___	___	___
High blood pressure?	___	___	___	___	___	___
Stroke?	___	___	___	___	___	___
Diabetes?	___	___	___	___	___	___
Lung disease?	___	___	___	___	___	___
Neurological disease?	___	___	___	___	___	___
Gastro-intestinal disease?	___	___	___	___	___	___
Genito-urinary disease?	___	___	___	___	___	___
Cancer?	___	___	___	___	___	___
Arthritic disease?	___	___	___	___	___	___

Deaths in family? ___mother ___father ___sister ___brother ___multiple siblings