

**CONFIDENTIAL PATIENT INFORMATION ( Please Print)**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's Lic. #/ State: \_\_\_\_\_  
 Marital Status: S M D W Minor Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M F  
 Pregnant? Y N # of children: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Name of Employer & Full Address: \_\_\_\_\_  
 Name of Spouse/ Guardian: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Employer's Full Address: \_\_\_\_\_  
 Spouse's Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

PCP/ Referring Doctor: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who May We Thank For Referring You To Us? \_\_\_\_\_

List your problems/complaints according to severity of pain:	Date started, or for how long	Did problem begin With injury?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Is this condition interfering with your:  Work  Sleep  Daily Routine  Exercise  
 other \_\_\_\_\_

What activities aggravate your condition?: \_\_\_\_\_

Other Doctors seen for this condition:  Medical Dr.  Chiropractor  Dentist  Other

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 When?: \_\_\_\_\_ What did they say was wrong? \_\_\_\_\_  
 2. Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 When?: \_\_\_\_\_ What did they say was wrong? \_\_\_\_\_

Are you taking any medications? Y N

What kind?: \_\_\_\_\_

Have you had any X-rays taken?

When: \_\_\_\_\_ Where: \_\_\_\_\_ Area of body: \_\_\_\_\_  
 When: \_\_\_\_\_ Where: \_\_\_\_\_ Area of body: \_\_\_\_\_

Do you wear orthotics or heel lifts? Y N

*( Continued On Back)*

Accidents/Injuries: Auto, work related, etc. (Especially those related to your present condition)

Type: _____	When: _____	Hospitalized? Y N
Type: _____	When: _____	Hospitalized? Y N
Type: _____	When: _____	Hospitalized? Y N
Type: _____	When: _____	Hospitalized? Y N

List any surgeries/hospitalizations:

Type: _____	When: _____	Doctor: _____
Type: _____	When: _____	Doctor: _____
Type: _____	When: _____	Doctor: _____
Type: _____	When: _____	Doctor: _____

Check the following you may have had at any time:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Allergy          | <input type="checkbox"/> Eczema            | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Pleurisy            |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Gall bladder      | <input type="checkbox"/> Pneumonia           |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout              | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Malaria           | <input type="checkbox"/> Ringing in ears     |
| <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Measles           | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Back pain         | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Miscarriage       | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Mumps             | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Neuritis          | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Low Blood Sugar  | <input type="checkbox"/> Whooping Cough    | <input type="checkbox"/> _____               |

To the best of my knowledge, all information is correct.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_