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### CONFIDENTIAL PATIENT INFORMATION

This information is confidential. In order for us to understand your health problems properly, please complete this form.

Date: \_\_\_\_\_ Chart #: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: S M W D # Children: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

How Did You Hear About This Office? \_\_\_\_\_

Diagnosing/Referring Practitioner: \_\_\_\_\_

Please List the Main Health Problems You Would Like to Be Free of in Order of Importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

How And When Did These Conditions Begin? \_\_\_\_\_

How Do They Impair Your Daily Activities? \_\_\_\_\_

Health Professionals Seen for Them \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**WHAT SURGERIES HAVE YOU HAD?**

(Type/When/Doctor/Results) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)**

(What/When/Symptoms/Treatment) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BROKEN BONES, DISLOCATIONS?**

(When/How/Doctor/Results) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE**

(What/Frequency/Doctors/Side Effects/Remarks) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED**

(Ex: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression)  
\_\_\_\_\_  
\_\_\_\_\_

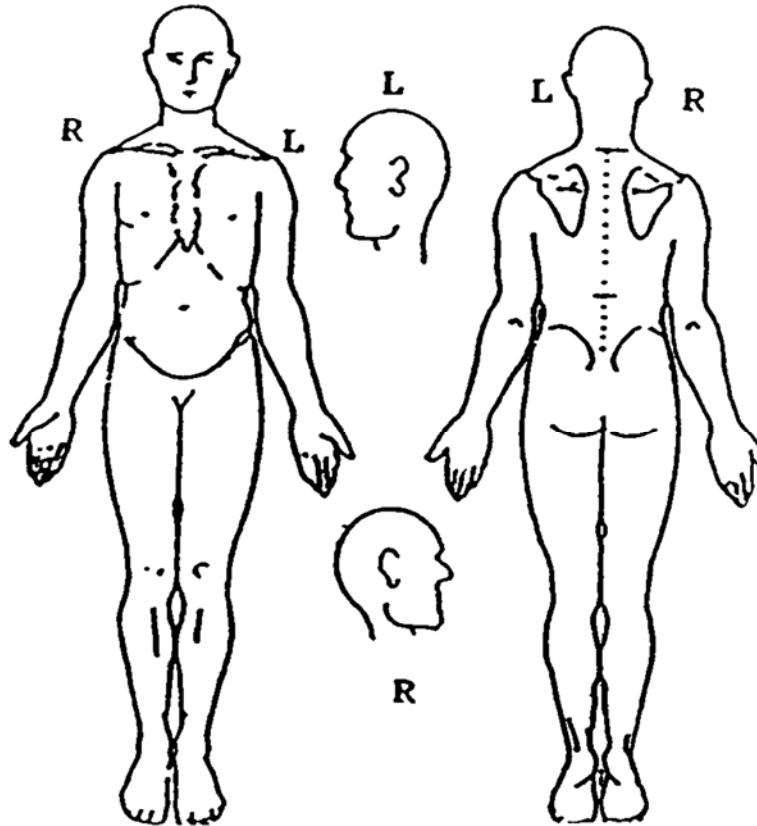
**WORK ACTIVITIES**

Work Responsibilities – Lifting, bending, stooping, turning, twisting, carrying, walking, standing, sitting etc.

\_\_\_\_\_  
\_\_\_\_\_

**LEISURE ACTIVITIES**

Sports and exercise type, frequency, length of time, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT, ON THE DIAGRAM ABOVE

Pain is: (check all that apply): Sharp  Burning  Moving  Fixed  Dull  Aching   
 Stabbing  radiates to: \_\_\_\_\_

Please check if you ever have had any of the following	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Hives
<input type="checkbox"/> Positive test for AIDS/HIV antibodies	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Kidney or bladder infection
<input type="checkbox"/> Bone disease	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Lupus
<input type="checkbox"/> Cancer or tumor	<input type="checkbox"/> Malaria
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles
<input type="checkbox"/> Colon/bowel disease	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Polio
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Prostatitis
<input type="checkbox"/> Drug habit	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Drug sensitivity or reaction	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Emotional or mental problems	<input type="checkbox"/> Small pox
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Spinal meningitis
<input type="checkbox"/> Gall stones	<input type="checkbox"/> Stomach or duodenal ulcer

<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	German measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	Thyroid or goiter trouble
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Typhoid
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	Hepatitis/jaundice	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	

If you have had any of the following symptoms, check the box that tells us if the symptom was in the past or if it is current. Also, circle one of the numbers that appears to the right of the symptom.

**(Circle 1 for the least severe, and 5 for the most severe.)**

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach pain	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or extended hoarseness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Always hungry	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulties	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Black stools	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sounds/ringing in ears	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Gas	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with your eyes	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Unusual taste in mouth	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Overweight	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Itching or burning skin	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Unusually thirsty	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Weight changes	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Burning urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding easily	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficult urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells or blackouts	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Urination at night	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sexual function	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Pounding heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Depression	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Racing heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue or tiredness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chest colds	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty getting to sleep	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Congested nose	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty staying asleep	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Smoking	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or trembling	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chills	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Stuttering or stammering	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Back trouble	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Fever	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Pain or swelling-any joint	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful feet	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful muscles	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too cold	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Stiff or painful neck	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too hot	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or legs	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Earaches	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>		1 2 3 4 5

Check if you have family history of any of these					
<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Problems with alcohol
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Other potentially inheritable disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	

**The Following Section is for Women**

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or cramping with menstruation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP smear	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	I.U.D.	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Abortion	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Back pain with menstruation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual tension/syndrome	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between periods	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>		1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding during or after intercourse	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bloating before periods	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Scanty bleeding with period	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Blood discharge from nipples	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sickness/weakness with period	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Heavy bleeding with period	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal dryness or itching	1 2 3 4 5
Duration of menstrual periods:							
Interval between periods:							
Dates of last period:							
Number of births you have had							
Ages of your children:							
Birth control method you use:							