CONFIDENTIAL PATIENT HISTORY

PLEASE COMPLETE AND SIGN THIS QUESTIONNAIRE
IF YOU HAVE ANY QUESTIONS PLEASE ASK THE STAFF FOR HELP

Name____ **Social Security #**_____________________

Address______________________________ **City**____________________ **State**_____ **Zip**______

Home Telephone____________________ **Cell Phone**____________________ **E-Mail**_____________

Birth Date______________ **Age**___________ **Marital Status:M S W D # Children**_____________

Referred By______________________________

Patients Employer______________________________ **Work Telephone**______________________

Address____

HEALTH INFORMATION

What is your major Complaint?________________________________

____

When did your problem Begin?________________________________

Describe how your problem began______________________________

____

Have you been in an accident? Auto [ ] Work [ ] Other[ ]____________

If yes , when__________ **Describe**______________________________

Other doctors who recently treated this condition____________________

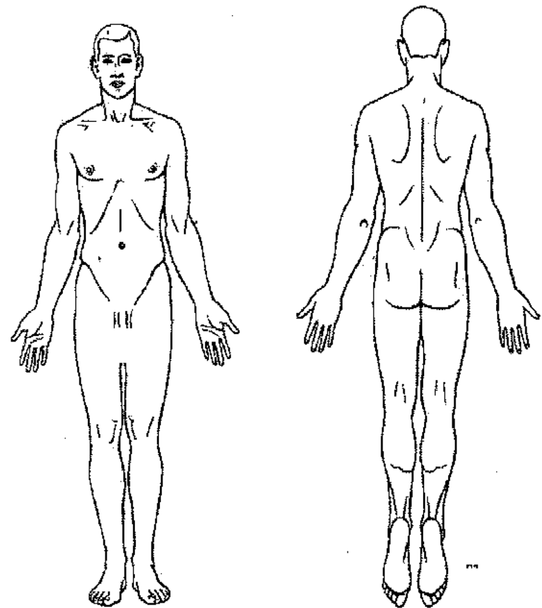
Have you had a similar condition in the past?_______________________

Since symptoms began they have; Increased [ ] Decreased [ ] Stayed the same [ ]

Are your symptoms ; Always present [ ] Frequent [ ] on and off [ ]

How bad is your pain? 0= no pain 10= lots of pain 1 2 3 4 5 6 7 8 9 10

Please mark your areas of pain in the figures below



What makes your symptoms worse?____

What makes your symptoms better?____

Describe your pain; sharp[ ] dull/ache [ ] numbness/tingling [ ] burning [ ] stabbing[ ] throbbing [ ]

HEALTH INFORMATION CONTINUED

Have you ever suffered from

	PAST	PRESANT
Dizziness	[ ]	[ ]
Convulsions	[ ]	[ ]
Loss of bladder control	[ ]	[ ]
Abdominal pain	[ ]	[ ]
Aortic Aneurism	[ ]	[ ]
Difficulty swallowing	[ ]	[ ]
High blood pressure	[ ]	[ ]
Kidney stones	[ ]	[ ]

	PAST	PRESANT
Stroke	[ ]	[ ]
Blood disorders	[ ]	[ ]
Heart problems	[ ]	[ ]
Asthma	[ ]	[ ]
Cancer	[ ]	[ ]
Prostate problems	[ ]	[ ]
Diabetes	[ ]	[ ]
Hiv/Aids	[ ]	[ ]

Present weight________ Height _______Feet _____Inches Rt handed____ Left handed_________

List surgical operations and year____

____

List medications you are taking____

____

Are you pregnant? Yes [ ] No [ ] Do you wear orthotics? Yes [ ] No [ ]

USE THIS ARE TO WRITE ANY ADDITIONAL CONCERNS YOU HAVE OR ANY INFORMATION THE DOCTOR SHOULD KNOW ABOUT YOUR HEALTH

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I UNDERSTAND THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I FURTHERMORE UNDERSTAND THAT MY DOCTOR WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANYAND THAT ANY AMOUNT TO BE PAID DIRECTLY TO MY DOCTOR AND WILL BE CREDITED TO MY ACCOUNT APON RE-CEIPT. HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE AND TREATMENT . ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. IN THE EVENT OF NON PAYMENT . I AM LEGALLY RESPONSIBLE FOR ANY COLLECTION FEES INVOLVED IN SATISFYING MY DEBT.

Patients signature ____ **Date**____________________

Guardians or spouse's signature ____________________________ **Date**____________________