

PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____
Last _____ First _____ Middle Initial _____
Address _____ City _____ ST _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
Email _____ May we send you our online newsletter? yes no
Your Occupation _____ Employer _____
How did you hear about our office? (Circle One) Office Sign Yellow Pages Newspaper Website
If another person, whom? Family member _____ Friend _____ Co-worker _____
Have you been to another doctor for this problem? yes no Who/Where? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Numb/tingling Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Numb/tingling Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

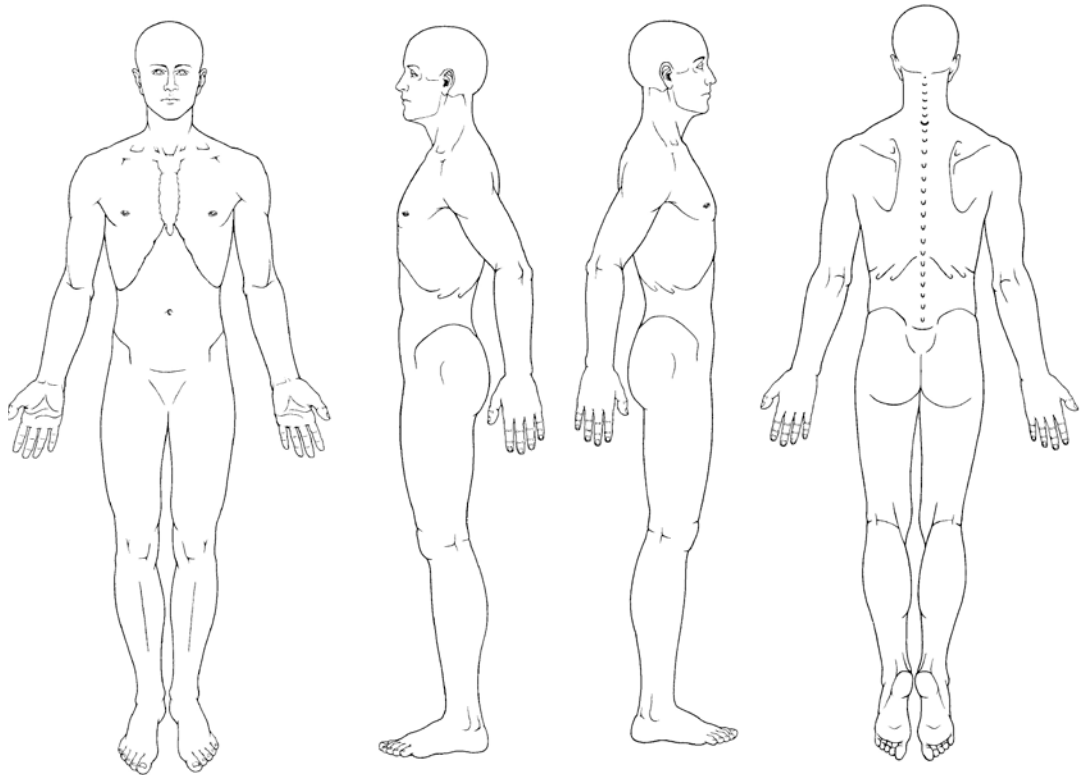
Do you smoke? yes no Have you ever smoked in the past? yes no
If yes, when did you quit? _____ Are you currently pregnant? yes no
Do you take birth control? yes no Have you ever taken birth control in the past? yes no
Do you consume alcohol? yes no If yes, how many drinks per week? _____
Do you consume caffeine? yes no If yes, how many drinks per day? _____
Do you exercise? yes no If yes, how many times per week and what type? _____
Do you have a high stress level? yes no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

PATIENT SIGNATURE _____ DATE _____

Please mark off the areas of your complaint on the diagram above with the following indicators:

- PPP = pain
- NNN = numbness
- TTT = tingling
- BBB = burning
- CCC = cramping
- XXX = other



Please list all surgeries, injuries, accidents, falls, etc with dates: _____

Please check if you have /had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other:				

PATIENT SIGNATURE _____ DATE _____

Emergency Contact

Name: _____ Phone Number: (____) _____ - _____

Address: _____ Relationship: Spouse Relative Friend Other _____

Employment Information – Job description RETIRED DISABLED
UNEMPLOYED

Business Name: _____ Occupation/Job Title: _____

Business Address: _____ Name of Supervisor: _____

Business Phone: (____) _____ - _____ Type of Work: _____ Work: ____ hrs/day or ____ per week

Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Insurance Information:

Who is responsible for your bill? YOU and... (Mark appropriate box(es)) Myself ONLY Spouse

Worker's Comp Auto Insurance Medpay claim Medicare Medicaid Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Social Security #: _____ - _____ - _____ PolicyHolder's Birthday Date: _____

Primary Care Physician: _____ Carolina Access Number: _____

Workers Compensation Injury / Auto / Personal Injury No **Have you filed an injury report** Yes

Carrier: _____ Policy # _____

Carriers Phone #: (____) _____ - _____ Adjuster: _____

Claim #: _____ Date: ____/____/____ Time: _____ am/pm

Attorney name: _____ Attorney Phone #: (____) _____ - _____