Confidential Patient Information

Name:_____ Data:_____
Address:_____ City:_____ __State:_____ Zip:_____
Phone (Home):_____ (Work):_____ (Mobile):_____
Email:_____ Referred By:_____
Age:_____ Birth Day:_____ Social Security No:_____ Sex: M / F Marital Status: S / M / W / D
Occupation:_____ Employer:_____
Spouse's Name:_____ Spouse's Work Phone:_____ Number of Children:_____
Emergency Contact:_____ Contact Phone:_____

Height:_____ Weight (current)_____ One Yr. Ago:_____ Adult Max:_____ Age:___ Adult Min:_____ Age:____
Known Allergies:_____
_____
Blood Type:_____ Have You Ever Had A Blood or Plasma Transfusion? Yes / No

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Date of Last Physical Exam:_____ With Whom:_____ Where:_____
Reported Findings:_____
Surgeries, Hospitalizations, Serious Illnesses(List Year in Brackets):_____
_____
Fractures, Dislocations, Major Dental Work (List Year in Brackets):_____

Conditions You Have Had:

_ AIDS/HIV	_ Depression	_ High Blood Pressure	_ Prostate Problem
_ Alcoholism	_ Diabetes	_ High Cholesterol	_ Prosthesis
_ Allergies	_ Digestive Disorders	_ Hypoglycemia	_ Rheumatic Fever
_ Anemia	_ Dizziness	_ Neck Pain	_ Sinus Troubles
_ Anorexia	_ Epilepsy	_ Nervousness	_ Stroke
_ Arthritis/Joint Pain	_ Fatigue	_ Neuritis	_ Tuberculosis
_ Asthma	_ Gout	_ Numbness	_ Ulcer
_ Backaches	_ Headaches	_ Osteoporosis	_ Urinary Trouble
_ Bleeding Disorders	_ Heart Trouble	_ Pacemaker	_ Venereal Disease
_ Breathing Problems	_ Hepatitis	_ Parasites	_ Weight Loss
_ Bulimia	_ Hernia	_ Pinched Nerve	_ Yeast/ Candida
_ Cancer	_ Herniated Disk	_ Poor Circulation	_ _____

Purpose of Appointment:_____
_____
Other Doctors Seen For This Condition:_____
Have You Ever Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe):_____
_____
Medications/Drugs You Are Taking (State Reason in Brackets Following Drug):_____
_____

Insurance Information:
Who is responsible for this account?_____ Relationship To Patient:_____
Insurance Co:_____ Policy #:_____ Group #:_____

Assignment And Release
I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to _____ all insurance benefits, if any, otherwise payable that any missed appointment without a 24-hour notice is subject to a $25.00 fee. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Habits:

Do you Smoke? Y / N What?_____ How Many / Day:_____ Since When?_____

Other Tobacco Products? Y / N What?_____ How Many / Day:_____ Since When?_____

Drink Coffee? Y / N Cups / Day?_____ Drink Caffeinated Tea? Y/ N Cups / Day?_____

Colas / Soft Drinks? Y / N Number / Day?_____ Glasses of Water / Day?_____

Alcoholic Beverages? Y / N Avg. No. / Wk?_____ Mostly What?_____

Do You Eat Red Meat? Y / N Are You A Vegetarian? Y / N If So, For How Long:_____

Are You Dieting Y / N If So, Describe:_____

Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week?_____

List Nutritional Supplements You Take:_____

Bowel Movement Frequency:_____ Difficulty? Y / N Approximate # of Times You Urinate / Day:_____

Do You Sleep Well? Y / N If No, Describe:_____ Average Hours / Night:_____

Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe:_____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right:_____/20 Left:_____/20

Has Your Vision Changed Recently? Y / N Explain:_____

Do You Wear Heel Lifts or Foot Supports? Y / N Explain:_____

XRAY HISTORY: (Include Cat, Mir, Dye Studies, and Dental) When was most recent x-ray/other study?_____

Age	Body Area	Type (normal X-ray, CAT, MRI, ect.)	No. of Studies

	Living	Age or Age of Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Despise	High blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset:_____ Are your Periods Regular? Y / N Cycle:_____ days(start to finish) Use Birth Control Pill? Y / N

Your Flow Is: Heavy Medium Light Date of Last Period:_____ Are You Pregnant? Y / N How Many Months:_____

Cramping? Y / N PMS? Y / N Other Menstrual / Hormonal Symptoms:_____

Vaginal Infections? Y / N Miscarriage? Y / N