Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION		Today's Date:
Name;		Date of
Name: Birth:	Email Address:	
Mailing Address: Zip:	City:	State:
Home Phone:	Work Phone:	
Marital Status: ☐ Married ☐ Name of Spouse or Nearest R Your Occupation Referred to this Office by: ☐F	Single DDivorced DSeparate elative:	ed □Other Phone: ployer:
(Please indicate which conditions S M F	dislocated joints dislocated joints depilepsy	S M F O O O neck pain nervousness numbness polio poor circulation hepatitis hepatitis hepatitis hepatitis hepatitis scarlet fever serious injury sinus trouble tuberculosis yenereal disease
1. 2. 3. Have you ever had a metal implant? ACCIDENT HISTORY:	Date:	n gunshot?
QJob QA	Auto Other 3.	Date:

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Please Rate Your symptoms(1-with 1	-10,
being least serious)	
1	
2	
3	
4	
5	
6	
SYMPTOMS ARE WORSE IN DMORNING DAFTERNOON DNIGHT	
WHEN AND HOW OCCURRED?	
SYMPTOMS DEVELOPED FROM: GJOB RELATED INJURY GAUTO ACCIDENT GOTHER GACCIDENT GILLNESS GUNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: SYMPTOMS HAVE PERSISTED FOR # HOUR(S) DAY(S) WEEK(S) MONTH(S) YEAR(S) SYMPTOMS/COMPLAINTS: GCOME & GO GARE CONSTANT HAVE YOU EVER HAD THIS BEFORE: GNO GYES WHEN? IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):	
ARE YOU ALLERGIC TO ANY MEDICATIONS LINO LIYES WHAT KIND?	
KIND? ARE YOU PREGNANT UND UYES DATE OF LAST MENSTRUAL PERIOD PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION: DBENDING UREACHING USTRAINING AT STOOL UCOUGHING USITTING UTURNING HEAD LIFTING USNEEZING UWALKING USTANDING	
PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION: BENDING DIFTING DIFTING DISTANDING DEVING DOWN DIVENING HEAD DEACHING DWALK PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING: Double disjoin Devizing in ears Double feet Double hands Double sweats Double note in loss /confusion Double constitution of the confusion Developeration in the confusion Developeration Developeratio	ation
Patient's Signature:	
Date:	

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE

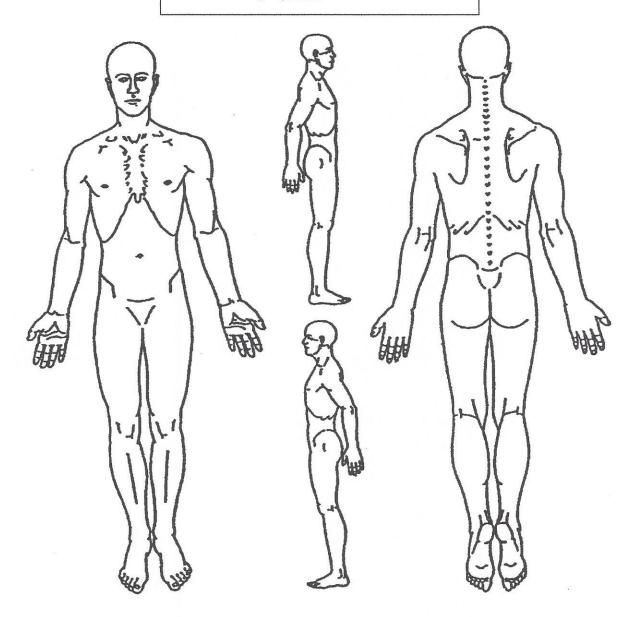
B = BURNING

S = STABBING

N = NUMBNESS

P = PINS & NEEDLES

O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN										SEVERE	PAIN
0	1	2	3	4	5	6	7	8	9	10	

Patient	Signature	Date	

What's in a number?

How to rate your symptoms, 1 - 10

- 10 Your pain is intense, constant, greatly restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain.
- 9 Same as above, but you can forget about the pain up to 15 minutes at a time.
- 8 The pain is significant, moderately intense at times, but not constant. Most activities are affected, you think about it once or twice an hour.
- 7 Same as above, except that the pain is never intense.
- 6 The pain is moderate yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.
- 5 Same as above, except that almost no activities are affected.
- 4 The pain is little more than a nuisance, and you go through the whole day frequently aware, but never affected by it.
- 3 Same as above, except that the awareness of the pain may be absent for a whole day at a time.
- 2 At it's worst, the pain is best described as "a little uncomfortable". Days can go by without being aware of it.
- 1 Same as above, except that the symptom does not recur more frequently than once a week.

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