

# CONFIDENTIAL PATIENT INFORMATION

**This information is confidential.**

**In order for us to understand your health problems properly, please complete this form.**

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

Name: \_\_\_\_\_ Home Ph.#: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Ph. #: \_\_\_\_\_

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

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

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

Address: \_\_\_\_\_ Office Ph#: \_\_\_\_\_

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

Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Other Nearest Relative: \_\_\_\_\_ Phone #: \_\_\_\_\_

| Please Place a Check Next to Your Symptoms (Check all that currently apply): |   |  |   |
|--|---|--|---|
| Neck Pain <input type="checkbox"/>   | Mid Back Pain: <input type="checkbox"/> | Low Back Pain <input type="checkbox"/> | Headaches/Head Pain <input type="checkbox"/>        |
| Shoulder Pain <input type="checkbox"/>                                       | Elbow Pain <input type="checkbox"/>     | Wrist Pain <input type="checkbox"/>    | Arm/Hand Pain or Numbness <input type="checkbox"/>  |
| Rib Cage Pain <input type="checkbox"/>                                       | Hip Pain <input type="checkbox"/>       | Knee Pain <input type="checkbox"/>     | Thigh/Leg Pain or Numbness <input type="checkbox"/> |
| Foot/Ankle Pain <input type="checkbox"/>                                     | Chest Pain <input type="checkbox"/>     | Groin Pain <input type="checkbox"/>    |   |

Other: \_\_\_\_\_

**DOCTORS CONSULTED FOR THIS CONDITION:**

|                              |                               |                       |
|------------------------------|-------------------------------|-----------------------|
| Hospital Name: _____         | Date Admitted: _____          | Discharge Date: _____ |
| Treatment: _____             | Follow up Instructions: _____ |                       |
| Dr. Name: _____              | When Consulted _____          |                       |
| Treatment Offered: _____     | Results: _____                |                       |
| Dr. Name: _____              | When Consulted _____          |                       |
| Treatment Offered: _____     | Results: _____                |                       |
| Present Family Doctor: _____ | Town: _____                   | Last Physical: _____  |

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## FINANCIAL INFORMATION:

Health Insurance Company: \_\_\_\_\_  
ID #: \_\_\_\_\_

Policy #: \_\_\_\_\_  
Insured: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_  
ID #: \_\_\_\_\_

Policy #: \_\_\_\_\_  
Insured: \_\_\_\_\_

Attorney Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone #: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

## 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. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_