Confidential Patient Data

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

Patient Information

Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____City: _____State: ___ Zip:_____

Home Phone:_____Work Phone: _____Cell Phone: _____

Email: _____SSN: _____-____-_____

Age: _____Height:_____Weight:_____Gender: □ Male □ Female

Marital Status: □Married □Single □Divorced □Other_____

Name of Spouse or Nearest Relative:_____Phone:_____

How were you referred to our office: □Friend/Family Member – Name?_____

□Doctor – Name?_____□Google □Yellow Pages □Mail □Clinic Location □Other_____

Payment for Services will be by: □Cash □Check □Credit Card □Health Insurance

□Automobile Insurance □Worker's Compensation

Your Occupation:_____Your Employer:_____

Insurance Company: _____Insured's Employer:_____

Insured's SSN: ____-___-____DOB:_____Employer's Phone#:_____

Relationship to Insured: _____Are you covered by a 2nd Insurance? □Yes □No

2nd Insurance Company: _____Insured's Employer:_____

Insured's SSN: ____-___-____DOB:_____Employer's Phone#:_____

Relationship to Insured: _____

Primary Care Physician:_____Phone:_____

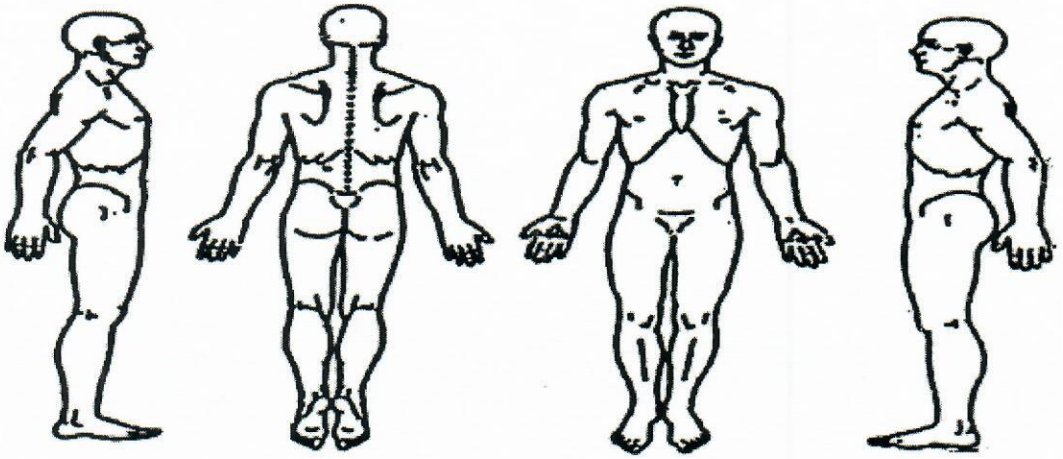
Orthopedist/Neurologist/Physical Therapist:_____Phone:_____

~~~~~~~~~~~~~~~~~~~~~~~~~~***How Can We Help You?***~~~~~~~~~~~~~~~~~~~~~~~~

1. Is today's problem caused by: □ Auto Accident Date of Accident _____

□ Work related accident Date of Accident _____□Other _____ Please explain:_____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)

□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)
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4. How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (***Please circle***)

7. Please list what makes your symptoms better. (i.e., ice, heat, medicine, activities)

_____
_____
_____
_____

8. Please list what makes your symptoms worse. (i.e., bending, lifting, standing)

_____
_____
_____
_____

9. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

10. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

11. Who else have you seen for your problem?

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	□ None

Date of most recent visit:_____

12. How long have you had this problem? _____

13. How do you think your problem began?

_____

14. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

19. Are you currently a tobacco user?

□ Yes □ No

18. If no, have you ever used tobacco user?

□ Yes □ No

21. Frequency of alcohol use?

□ None □ Seldom □ Light □ Moderate

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

Has your family had any of the above? □ Yes □ No
Indicate by placing an **M**-Mother, **F**-Father, **S**-Sister or **B**-Brother in between past & present columns above

21. List all prescription medications you are currently taking:

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Manual Labor:**	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes
If yes, why _____

27. Have you had significant past trauma? □ No □ Yes
If yes, please explain _____

28. Have you ever been in a motor vehicle accident? □ No □ Yes
If yes, when & briefly describe_____ _____

29 Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

□St. Charles Clinic □St. Louis Clinic □West County Clinic