

PATIENT INFORMATION

Date ____/____/____

Patient Name (last, first) _____ Preferred Name _____

Home Phone (____) _____ Work Phone # (____) _____ Cell # (____) _____

Social Security # _____ E-Mail Address _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth ____/____/____ Age _____ Sex: M F Patient Employer _____

Work Address _____ City _____ State _____ Zip Code _____

Occupation / Job Description _____

Marital Status (circle one): Single Married Widowed Divorced Separated Domestic partner _____

Note: (Only fill out this section if the patient is different from the insured) Insured Name: _____

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Home Phone # (____) _____ Date of Birth ____/____/____

Insured Employer _____ Work Phone # (____) _____

Work Address _____ City _____ State _____ Zip Code _____

Review of Systems: Please write in a number: 1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO ACCIDENT

General

- ___ Allergy
- ___ Chills
- ___ Convulsions
- ___ Dizziness
- ___ Fainting
- ___ Fatigue
- ___ Fever
- ___ Headache
- ___ Sleep loss
- ___ Weight loss/gain
- ___ Nervousness/depression
- ___ Neuralgia
- ___ Numbness
- ___ Sweats
- ___ Tremors
- ___ Anxiety / Depression

Eyes, Ears, Nose, Throat

- ___ Asthma
- ___ Colds
- ___ Sore throat
- ___ Deafness
- ___ Dental decay
- ___ Earache/noises
- ___ Ear discharge
- ___ Sinus infection
- ___ Enlarged glands
- ___ Enlarged thyroid
- ___ Nose bleeds
- ___ Failing vision
- ___ Far sighted
- ___ Gum trouble
- ___ Near sighted
- ___ Hoarseness
- ___ Nasal obstruction

Musculoskeletal

- ___ Arthritis
- ___ Bursitis
- ___ Foot trouble
- ___ Hernia
- ___ Low back pain
- ___ Lumbago
- ___ Neck pain/stiffness
- ___ Shoulder blade pain
- Pain or numbness in:
 - ___ Shoulders
 - ___ Arms
 - ___ Elbows
 - ___ Hands
 - ___ Hips
 - ___ Legs
 - ___ Knees
 - ___ Ankles
 - ___ Feet
 - ___ Painful tailbone
 - ___ Poor posture
 - ___ Sciatica
 - ___ Spinal curvature
- Genito-urinary**
- ___ Bedwetting
- ___ Blood in urine
- ___ Frequent urination
- ___ Inability to control bladder
- ___ Kidney infection or stones
- ___ Painful urination
- ___ Prostate trouble
- ___ Pus in urine
- ___ Painful menstruation
- ___ Hot flashes
- ___ Irregular cycle
- ___ Lumps in breasts

Cardiovascular

- ___ Hardening of arteries
- ___ High blood pressure
- ___ Low blood pressure
- ___ Pain over heart
- ___ Poor circulation
- ___ Rapid heart beat
- ___ Slow heart beat
- ___ Swelling of ankles

Respiratory

- ___ Chest pain
- ___ Chronic cough
- ___ Difficult breathing
- ___ Spitting up blood
- ___ Spitting up phlegm
- ___ Wheezing

Gastrointestinal

- ___ Belching or gas
- ___ Colitis
- ___ Colon trouble
- ___ Constipation
- ___ Diarrhea
- ___ Difficult digestion
- ___ Distention of abdomen
- ___ Excessive hunger
- ___ Heartburn / reflux
- ___ Gall bladder trouble
- ___ Hemorrhoids
- ___ Intestinal worms
- ___ Jaundice
- ___ Liver trouble
- ___ Nausea
- ___ Pain over stomach
- ___ Poor appetite
- ___ Vomiting
- ___ Vomiting blood

DOCTOR ONLY: _____

Patient Name: _____

Date: ____/____/____

Current Medication: Please list the name and dosages, if possible.

(Include all vitamins, herbal supplements, and over-the-counter medications.)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Allergies (medication, food, other substance): Please list and state the reaction you had:

Date of your last physical exam / doctor visit: ____/____/____ **Results of exam:** _____

Family History: Check any diseases which your relatives have had (if known):

Relatives	Arthritis	Cancer	Diabetes	Heart Disease/ Stroke	Kidney Disease	Neurological Disease	Thyroid Disease
Father							
Mother							
Brothers/Sister							
Grandparents							

DOCTOR ONLY: _____

Hospitalizations / Surgeries (please list procedures, dates and locations): _____

Previous Injuries (sprains, fractures, auto or other accidents, etc.) _____

Personal Habits – Please answer honestly. *All information is confidential.*

Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

	1	2	3	4	5	Elaborate
Exercise Regularly (3-4 x week)						
Wear Seat Belts						
Recreational Drugs						
Drink Alcohol						
Smoke						
Chew Tobacco						
Experience Stress						
Other						

Patient Name: _____

Date: ____/____/____

Women Only

Menstrual Periods: Age Onset ____ Regular? Yes No Length of Period _____

Date Last Period Began ____/____/____ Average cycle length _____

Difficulty with Periods? Yes No Specify: _____

Age at Menopause (if applicable): _____ Date of last Pap Smear / Pelvic Exam? ____/____/____

Number of Children: Born Alive ____ Cesarean ____ Premature ____ Stillborn ____ Miscarriages ____

Describe Pregnancy or Other Complications (if applicable):

Nutritional Information

Please indicate what you eat in a typical week Breakfast Lunch Dinner #Snacks _____

Indicate the estimated number of servings of each of the following items consumed in a **typical week**

- | | | | | |
|-----------------------|--------------------|------------------|---------------------|-----------------|
| ___ Eggs | ___ Red Meat | ___ Nuts/Seeds | ___ Butter | ___ Spicy Food |
| ___ Cheese | ___ Pork/Ham/Bacon | ___ Nut Butter | ___ Margarine | ___ Junk Food |
| ___ Milk (type _____) | ___ Chicken/Turkey | ___ Fruits | ___ Olive oil | ___ Fast Food |
| ___ Yogurt | ___ Fish | ___ Vegetables | ___ Canola oil | ___ Desserts |
| ___ Sour Cream | ___ Beans | ___ Rice/Pasta | ___ Corn oil | ___ Other _____ |
| ___ Ice Cream | ___ Tofu/Soy | ___ Bread/Cereal | ___ Sunflower | ___ Other _____ |
| ___ Other _____ | ___ Lunch Meats | ___ Other _____ | ___ Other oil _____ | ___ Other _____ |

Any foods not listed and consumed regularly _____

Indicate the estimated number of servings (6-8oz cups) of the following consumed in a **typical day**

- | | | |
|--------------------------|-------------------------|-------------------|
| ___ Caffeinated Coffee | ___ Green Tea | ___ Water |
| ___ Decaffeinated Coffee | ___ Regular Soft Drinks | ___ Fruit Juice |
| ___ Regular Tea | ___ Diet Soft Drinks | ___ Sports Drinks |
| ___ Herbal Tea | ___ Diet Drinks / Aids | ___ Other _____ |

Any drinks not listed and consumed regularly _____

On a scale of 1-10 (10 being extremely healthful), how healthful do you rate your diet? ____/10

If you try to follow a specific diet, please describe the diet and why you follow this type of diet:

If you would like to have a nutritional consultation, please indicate any specific goals and/or questions:

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance:

What do you hope to better enjoy when you regain your health? _____

DOCTOR ONLY:

