CONFIDENTIAL PATIENT INFORMATION

Date___________________ ***Please use the back of this form for additional information if necessary***

Name____ Sex________ Marital Status ________ D.O.B._____/_____/______ Age_______
First, MI, Last — M or F — Mo/Day/Year

Home Phone ___________________ Work Phone _________________ Email ______________________________

Address____ City____________________ State_______ Zip Code_____________
Include street type such as St., Ave., etc.

____
Social Security Number Occupation Company Name

____
Spouse's Full Name Spouse's Employer Names and Ages of Children

Who referred you to our office?____

MAJOR COMPLAINT(S), SYMPTOMS, PROBLEMS… (List by priority if more than one):

*1*____*2*____

*3*____*4*____

*5*____

When did this condition first begin?____

____

How often does this problem bother you? Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _______________________

Other Doctors seen for this condition? (use separate sheet if necessary) ____________________________________

____

____

Type of treatment: ____ Results: ______________

Can you relate it to a particular accident or injury? Y N Describe _______________________________________

____

Has the problem… Gotten Worse ☐ Gotten Better ☐ Persisted/Stayed the Same ☐ …since it first began

What makes the problem worse: ____

What makes the problem better: ____

Past Medical History: List all major illnesses, diagnosed diseases, accidents, all surgeries or hospitalizations:

____

____

____

Family Medical History: Does anyone in your family have (or had): Arthritis ☐ Alzheimers Disease ☐ Heart Disease ☐

Stroke ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Cancer ☐ Type(s) _______________________

Osteoporosis ☐ Other ____

Please rate your stress level on this scale: No Stress 1 2 3 4 5 6 7 8 9 10 Major Stress