

# PATIENT INFORMATION FORM

DATE : \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Gender Male Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ MSDW Martial Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Number of Children \_\_\_\_\_ Social Security Number \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ REFERRED BY (circle if Yellow Pages) \_\_\_\_\_

## Employer / Occupation

| Please list your reason(s) for this visit or your condition(s) in order of importance: | Date you first noticed: | Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), circle the number that best reflects your condition:<br>↓ none ..... to ..... severe ↓ | Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:    |
|--|-------------------------|--|---|
| 1. _____   | _____                   | 0 1 2 3 4 5 6 7 8 9 10   | <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% |
| 2. _____   | _____                   | 0 1 2 3 4 5 6 7 8 9 10   | <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% |
| 3. _____   | _____                   | 0 1 2 3 4 5 6 7 8 9 10   | <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% |
| 4. _____   | _____                   | 0 1 2 3 4 5 6 7 8 9 10   | <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% |

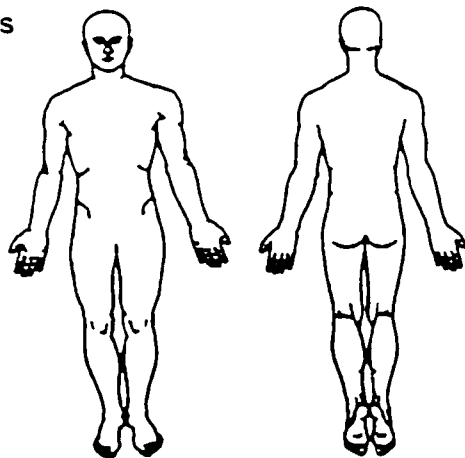
For each reason or condition listed above, please mark how it happened:

- |   |                                  |                                 |  |                                      |                                       |
|---|----------------------------------|---------------------------------|--|--------------------------------------|---------------------------------------|
| 1. <input type="checkbox"/> Developed over time | <input type="checkbox"/> Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I don't know |
| 2. <input type="checkbox"/> Developed over time | <input type="checkbox"/> Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I don't know |
| 3. <input type="checkbox"/> Developed over time | <input type="checkbox"/> Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I don't know |
| 4. <input type="checkbox"/> Developed over time | <input type="checkbox"/> Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I don't know |

For each reason or condition listed above, please check if it is better or worse with any of the following:

|    | HEAT                     |                          | COLD                     |                          | REST                     |                          | ACTIVITY                 |                          | OTHER (please describe on line below) |                          |       |
|----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|-------|
|    | better                   | worse                    | better                   | worse                    | better                   | worse                    | better                   | worse                    | better                                | worse                    |       |
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/> | _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/> | _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/> | _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/> | _____ |

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:



- +++ Sharp or stabbing
- ooo Pins and needles
- wv Dull or aching
- /// Numbness

Please check the box that best describes whether your pain or symptom(s) limit normal activities:

| Activity                | normal                   | somewhat limited         | severely limited         |
|-------------------------|--------------------------|--------------------------|--------------------------|
| Lifting                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climbing stairs         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Resting in bed          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intercourse             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Computer work/typing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Normal work             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Household activities    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (list below)      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- a. During what time of the day do you feel worse? \_\_\_\_\_
- b. Do you sleep well?  Yes  No What are your normal sleeping hours? \_\_\_\_\_ to \_\_\_\_\_
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?  
 No  Yes → For what condition? \_\_\_\_\_  
 Name of doctor/provider \_\_\_\_\_ Phone number \_\_\_\_\_
- d. Please list any medications you are taking, the dosage, reason for taking and the date you started.
- | Medication | Dosage | Reason | Date started |
|------------|--------|--------|--------------|
|            |        |        |              |
|            |        |        |              |

- e. Please list any allergies \_\_\_\_\_
- f. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?  
 No  Yes If yes, please describe each event below:
- | Event | Year |
|-------|------|
|       |      |
|       |      |
- g. Please check the boxes that best describes your digestion:  Good  Indigestion  Constipation  
 Diarrhea  Poor appetite  Cravings (describe) \_\_\_\_\_
- h. Do you exercise?  Yes  No If yes, please describe activity \_\_\_\_\_  
 How many days a week? \_\_\_\_\_ How many minutes per session? \_\_\_\_\_

**Questions i through k: FOR WOMEN ONLY IF APPLICABLE**

- i. Are you currently pregnant?  Yes  No Number of pregnancies? \_\_\_\_\_ Number of births? \_\_\_\_\_
- j. Are you nursing?  Yes  No
- k. **Menstrual history:** How many days from the start of your period until the start of your next period? \_\_\_\_\_  
 Date of last period? \_\_\_\_\_ How many days do your periods last? \_\_\_\_\_  
 How regular is your period?  Regular  Irregular  
 Please check the box that best describes your period:  Scant, thin, red  Heavy, dark, clotted  Normal red flow  
 How do you feel before your period? Describe \_\_\_\_\_  
 How do you feel after your period? Describe \_\_\_\_\_

**Personal History**

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

- Pain in body**
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing   | <input type="checkbox"/> Recent progressive muscle weakness or shaking  | <input type="checkbox"/> Severe degenerative arthritis   |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F   | <input type="checkbox"/> History of compression fracture   |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting                       | <input type="checkbox"/> Loss of bowel or bladder control   | <input type="checkbox"/> History of heart attack   |
| <input type="checkbox"/> Loss of feeling in inner thighs  | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm   |
| <input type="checkbox"/> Back pain with urinary problems  | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head             | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer                         |
| <b>Types of pain</b>  | <input type="checkbox"/> Memory loss after injury   | <input type="checkbox"/> Diabetes with cold, burning or numb feet  |
| <input type="checkbox"/> Severe pain interrupts sleep   | <b>Previously diagnosed condition/ medical history</b>  | <input type="checkbox"/> Gout  |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down               | <input type="checkbox"/> Congenital bone or joint disorder  | <input type="checkbox"/> Lupus   |
| <b>Current conditions</b>   | <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Ankylosing spondylitis  |
| <input type="checkbox"/> Unable to balance when walking   |   | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc.              |
| <input type="checkbox"/> Recent unexplained weight loss   |   | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |

**Family History**

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Mental illness   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the Practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_