PATIENT INFORMATION

Date: _____ Name: _____

DOB: ____/____/____ Age: ____ Gender: ____ Height: _____ Weight: _____

SSN: _____

Address: _____

Street City State Zip

Telephone: Home ( )____-_____ Cell ( )____-_____ Work ( )____-_____

E-Mail: _____ Employer: _____

Occupation: _____

Who referred you to the office? _____

Emergency Contact: _____

Name Telephone

_____

INJURY INFORMATION / PURPOSE OF VISIT

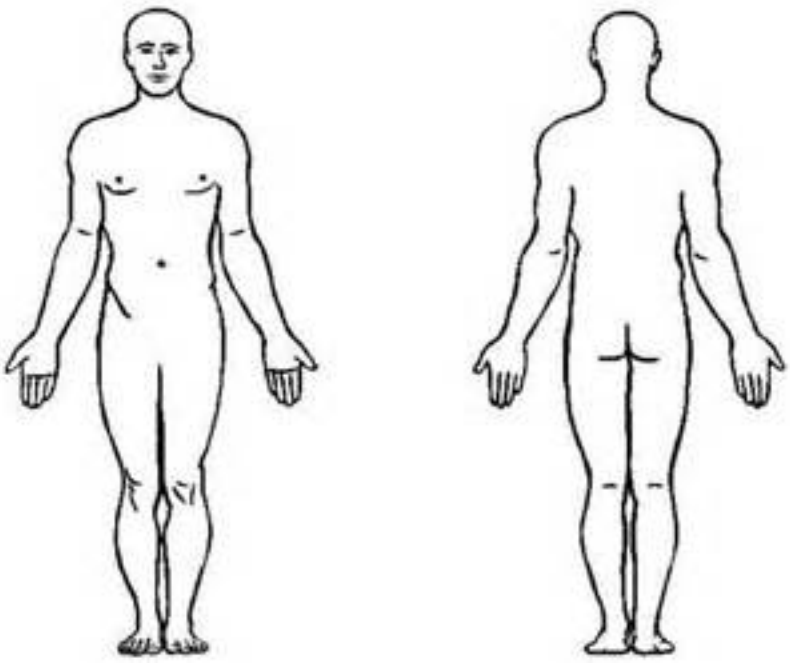
List the main problems you are having, or reason for this appointment: _____

_____

_____

_____

Please mark where it hurts:



When did the problem start? _____

What makes it feel better? _____

_____

_____

What makes it feel worse? _____

_____

_____

Does it hurt more in the: Morning Evening

Where does the pain go? _____

_____

Do you attribute your condition to a particular accident or illness (please indicate a date)? _____

_____

_____

Have you seen other doctors for this condition? _____

May we request relevant information from other physicians/clinics? _____

Date of last Physical Examination: ____/____/____

Have you been treated for health conditions in the last year? _____

Does your family have a history of kidney stones? _____

Are you or is there a chance you might be pregnant? _____

Have you lost any days of work? _____

Are you taking anti-depressants, or have you been treated for depression? _____

Have you been treated for any health condition not listed above? _____

_____

_____

_____

Major Illnesses: _____

_____

_____

_____

Accidents or major trauma (Please indicate location of any significant scars): _____

_____

_____

_____

Hospitalizations/Surgeries (indicate month/year if possible): _____

_____

_____

Dental Procedures such as root canals, fillings (# and type), etc: _____

_____

Current Prescription Medications (names and doses): _____

_____

_____

_____

_____

Please list any vitamins, minerals, herbal formulas, or other supplements you are taking:

Name	Manufacturer	Form	Dosage	Frequency
Example: Vitamin C	Key Co.	Tablet	250 mg	2/day

Allergies/Sensitivities (foods, environmental, etc): _____

_____

_____

_____

Have you been exposed to occupational chemicals (asbestos, fertilizer, toxic fumes, etc):

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please give age, lists of any illness, if deceased, list cause and age of death.

Mother: _____

_____

_____

Father: _____

_____

_____

Siblings: _____

_____

_____

Grandparents: _____

_____

_____

Children: _____

_____

WOMEN

Last Pap: _____ First day of last menstrual period: _____

Marital history: Years married: _____ # of children: _____ Ages: _____

# of Pregnancies: _____ Deliveries: _____ Complications: _____

LIFESTYLE FACTORS: Please write down what you eat and drink for a typical week. This includes juice, coffee, alcohol, tobacco, etc. If you are attempting to follow any particular diet, please indicate that in the space below the table, ie Atkins diet, Paleo diet, etc.

Diet Log	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							

Other: _____

_____

_____

_____

_____

Describe your exercise habits (if you are not exercising consistently, please indicate):

_____

_____

_____

_____

_____