

PATIENT INFORMATION

FULL NAME: _____

ADDRESS: _____ CITY _____ ZIP _____

SOC. SEC. No: _____ DR. LIC. No: _____

HOME PHONE : _____ CELL NUMBER: _____

EMAIL: _____

BIRTHDAY : _____ AGE : _____ SEX : _____ MARITAL STATUS: (M S W D)

EMPLOYED BY : _____ WORK PHONE : _____

WORK ADDRESS: _____ CITY: _____ ZIP : _____

OCCUPATION : _____ PERSON RESPONSIBLE FOR ACCOUNT : _____

SPOUSE NAME .: _____ SPOUSE EMPLOYED BY : _____

WHO REFERRED YOU TO OUR OFFICE : _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME : _____ INSURANCE PHONE: _____

ADDRESS: _____ CITY: _____ ZIP : _____

SOC SEC NUMBER : _____ INSURED ID NUMBER : _____ GROUP NUMBER : _____

RELATIONSHIP TO PATIENT : _____ INSURED'S BIRTHDAY: _____

LOCAL NUMBER : _____ ILWU REGISTRATION # : _____ VESSEL NAME: _____

IS CONDITION DUE TO () AUTO ACCIDENT () WORK INJURY () ILLNESS () UNKNOWN CAUSE () OTHER

ARE SYMPTOMS () IMPROVING () GETTING WORSE () ABOUT THE SAME () COMES AND GOES (INTERMITTENT)

WHAT MAKES YOUR CONDITION WORSE : A) STANDING B) WALKING C) SITTING D) LYING E) BENDING F) LIFTING G) TWISTING

HAVE YOU HAD THESE SYMPTOMS BEFORE ? (YES / NO) IF YES WHEN ? _____

WHO HAVE YOU SEEN FOR THIS CONDITION ? A) MD B) CHIROPRACTOR C) OSTEOPATH D) ACUPUNCTURIST E) PHYSICAL THERAPIST

DR'S NAME: _____ DOCTOR/CLINIC PHONE : _____

ATTORNEY INFORMATION FOR PERSONAL INJURY CASES

ATTORNEY'S NAME : _____ ATTORNEY PHONE: _____

ATTORNEY ADDRESS: _____ CITY: _____ ZIP: _____

PERSONAL HISTORY

DO YOU USE ANY TRANQUILIZERS OR SLEEPING MEDICATIONS ? (YES / NO) IF YES WHICH ONE ? _____

LIST OF ANY MEDICATIONS YOU ARE CURRENTLY TAKING : _____

HAVE YOU HAD ANY BROKE BONES ? (YES / NO) IF YES WHICH ONE ? _____

HAVE YOU HAD ANY SPRAINS OR DISLOCATIONS ? (YES / NO) IF YES WHICH ONE ? _____

LIST ANY SURGERIES OR SERIOUS ILLNESS: _____

LIST ANY KNOWN ALLERGIES : _____

CHILD HOOD ILLNESS: () MEASLES () MUMPS () RUBELLA () CHICKENPOX () RHEUMATIC FEVER () POLIO

PATIENT INFORMATION

HEALTH CONCERNS (PLEASE MARK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> SEVERE OR FREQUENT HEADACHES | <input type="checkbox"/> LOWER BACK PAIN | <input type="checkbox"/> CONGENITAL HEART DEFECT |
| <input type="checkbox"/> LOSS OF SLEEP | <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> PAIN BETWEEN SHOULDERS | <input type="checkbox"/> ULCERS/COLITIS | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE |
| <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> HEART ATTACK/STROKE | <input type="checkbox"/> DIFFICULTY BREATHING |
| <input type="checkbox"/> NUMBNESS OR PAIN IN ARMS/LEGS | <input type="checkbox"/> SINUS PROBLEMS/ASTHMA | <input type="checkbox"/> REDUCED SEXUAL DRIVE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> HISTORY OF DRUG USE |
| <input type="checkbox"/> PINCHED NERVE(S) | <input type="checkbox"/> CANCER | <input type="checkbox"/> CHRONIC FATIGUE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> SKIN DISORDER |
| <input type="checkbox"/> ADD/ADHD/AUTISM | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> WEIGHT CHANGE |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> OSTEOPOROSIS | |
| <input type="checkbox"/> SHINGLES | <input type="checkbox"/> THYROID () HIGH () LOW | |
| <input type="checkbox"/> HERPES | <input type="checkbox"/> MEMORY PROBLEMS | |

HEALTH HABITS & PERSONAL SAFETY

DO YOU LIVE ALONE ?	() YES	() NO
DO YOU HAVE FREQUENT FALLS?	() YES	() NO
DO YOU HAVE VISION OR HEARING LOSS?	() YES	() NO
DO YOU HAVE AN ADVANCE DIRECTIVE AND/OR LIVING WILL?	() YES	() NO
IS STRESS A MAJOR PROBLEM FOR YOU ?	() YES	() NO
DO YOU FEEL DEPRESSED?	() YES	() NO
DO YOU PANIC WHEN STRESSED	() YES	() NO
DO YOU HAVE PROBLEMS WITH EATING OR YOUR APPETITE?	() YES	() NO
DO YOU CRY FREQUENTLY	() YES	() NO
DO YOU HAVE PROBLEMS SLEEPING	() YES	() NO
HAVE YOU EVER BEEN TO A COUNSELOR?	() YES	() NO
ARE YOU CURRENTLY TRYING TO GET PREGNANT ?	() YES	() NO
EXERCISE () SEDENTARY (NO EXERCISE) () MILD EXERCISE (STAIRS/WALKS 3 BLOCKS () REGULAR EXERCISE (3 TIMES A WEEK 30 MINS		
WHAT IS YOUR SALT INTAKE? () HIGH () MEDIUM () LOW () NONE FAT INTAKE () HIGH () MEDIUM () LOW () NONE		
CAFFEINE/COFFEE/SODA/TEAS () HIGH () MEDIUM () LOW () NONE ALCOHOL () HIGH () MEDIUM () LOW () NONE		
TOBACCO/CIGARETTES # OF PACKS PER DAY _____ CIGARS # PER DAY _____ CHEW # PER DAY _____ () QUIT		
DO YOU CURRENTLY USE RECREATIONAL OR STREET DRUG () YES () NO IF YES WHAT: _____		

PRESCRIPTION OR OTHER MEDICATIONS

MEDICATION NAME	REASON USE	DOSAGE
HERBAL/VITAMIN/SUPPLEMENTS	REASON USE	DOSAGE

FAMILY HEALTH HISTORY

AGE

LIST ANY HEALTH PROBLEMS

FATHER		
MOTHER		
GRAND FATHER (MOTHER SIDE)		
GRANDMOTHER (MOTHER SIDE)		
GRANDMOTHER (FATHER SIDE)		
GRANDMOTHER (FATHER SIDE)		
SIBLING () MALE () FEMALE		
SIBLING () MALE () FEMALE		
SIBLING () MALE () FEMALE		