Confidential Patient Information

Name _____ Social security# _____

Sex _____ Marital status : M S D W Number of children _____ Birthdate _____ Age _____

Home phone(____) ____-_____ Cell phone(_____)_____-_____ E-mail _____

Address _____ CITY _____ STATE _____ ZIP _____

Occupation _____ Employer _____ Work phone(____)_____-_____

Employer address _____ CITY _____ STATE _____ ZIP _____

Name of spouse _____ Spouse's occupation _____ Employer _____

Spouse's address _____ STATE ____ ZIP _____ Spouse's work phone(____) ____-_____

Person to contact in case of emergency _____ Phone(____) _____-_____

Referred by _____

Date of last physical exam _____

What operations / surgeries have you had? _____ When? _____

Serious illnesses? _____ When? _____

Name of persons responsible for payment _____ Do you have insurance? Yes No

Insurance company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt, I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian of Spouse's Signature Authorizing Care _____

Signature Authorizing Care _____ Date _____

Information Taken By _____ Date _____

please complete information on reverse side also

Reason for visit _____

When did this condition start? _____

Is this condition getting progressively (same ・ worse ・ better)

(constantly ・ come and go)

Which activities are difficult to perform? (sitting・standing・lying down・bending・walking・other)

Other doctors seen for this condition: Yes No Doctor / Hospital _____

Have you been treated for any health condition by a physician in the last year? Yes No

Describe _____

Are you taking any medication or drugs? Yes No Name _____

Check symptoms you have had before.

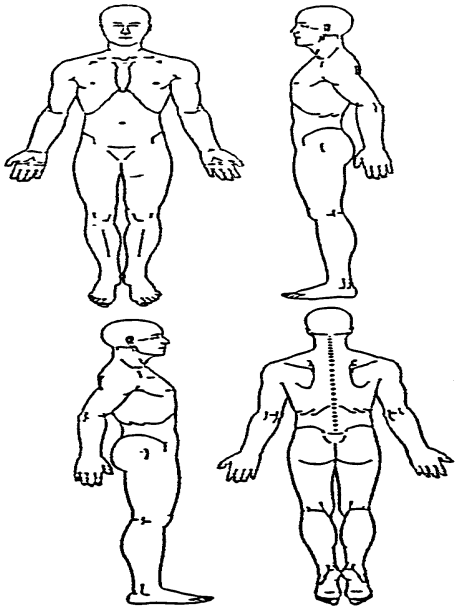
Neuromusculoskeletal system	Genitourinary system	Cardiovascular Respiratory system	Digestive system	Eye・Ear・Nose・Mouth・Throat	Others
[ ]Lower back pain [ ]Shoulder pain [ ]Neck/ Arms/ Legs [ ]Joint swelling [ ]Joint pain [ ]Muscle ache [ ]Muscle weakness [ ]Cramp [ ]Difficult walking [ ]Hernia [ ]Fractures [ ]Osteoporosis [ ]Rheumatoid arthritis [ ]numbness [ ]Anesthesia [ ]Dizziness [ ]Headache [ ]Loss of consciousness [ ]Loss of memory [ ]Confusion [ ]Depression	[ ]Kidney disease esp)_____ [ ]Bladder problem Urination [ ]Large amount [ ]Small amout [ ]Painful [ ]Abnomal color [ ]Prostate disease esp)_____ Venereal disease [ ]Gonorrhea [ ]Syphilis [ ] others **Only Female** [ ]excess discharge [ ]vaginal bleeding [ ]Endometriosis [ ]cervical cancer [ ]Breast cancer [ ]Breast pain [ ]Miscarriage **Are you pregnant?** **Yes ・ No**	[ ]Chest pain [ ]Heart disease [ ]Anemia [ ]Migraine Headache [ ]difficulty breathing [ ]Excess coughing [ ]Excess sputum [ ]bloody sputum [ ]fast heart beat [ ]Insomnia [ ]High blood pressure [ ]Low blood pressure [ ]Stroke [ ]Pacemaker [ ]Asthma [ ]Bronchitis [ ]Emphysema [ ]Pneumonia	[ ]Anorexia [ ]Bulimia [ ]Difficult swallowing [ ]frequently thirsty [ ]Nausea [ ]Vomiting food [ ]Vomiting blood [ ]Abdominal pain [ ]Diarrhea [ ]Constipation [ ]Hemorrhoid [ ]Appendicitis [ ]Polio [ ]Ulcers [ ]Diabetes [ ]Suddenly weight loss [ ]Liver disease esp)_____ [ ]Gallbladder disease esp)_____	[ ]Cataracts [ ]Glaucoma [ ]Earache [ ]Ear pain [ ]Tinnitus [ ]Difficult hearing [ ]Pus from ear [ ]Nose pain [ ]Nose bleeding [ ]Pus from nose [ ]Difficult breathing from the nose [ ]Gum pain [ ]teeth problems [ ]Mouth pain [ ]Hoarse [ ]Difficult speaking	[ ]AIDS / HIV [ ]Alcoholism [ ]Cancer [ ]Chicken pox [ ]Dpression [ ]Epilepsy [ ]Gout [ ]Herpes [ ]Measles [ ]Mononucleosis [ ]Multiple sclerosis [ ]Mumps [ ]Parkinson's disease [ ]Scarlet fever [ ]Tonsillitis [ ]Tuberculosis [ ]Tumors [ ]Typhoid fever [ ]Whooping cough [ ]other _____ _____ _____

Rate the severity of your pain.

(please check the number)

(Discomfort) (Severe pain)

1 2 3 4 5 6 7 8 9 10



Type of pain. (please make O)

Sharp・Dull・Aching・Throbbing

Burning・Tingling・Cramping

Stiffness・Swelling・Numbness

Other_____