Confidential Patient Health Record

Please do not leave any question blank.

Date_____ **Sex:** _____F _____M **Height**: _____ **Weight**: _____lbs

Last Name: _____ **First Name**: _____ **MI**: _____

Date of Birth: _____ **Age**: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Cell #**: _____ **Work #**: _____

E-mail:_____
Can we email you? Yes / No

Best way to reach you: Home / Work / Cell -- *Can we leave a message?* Yes / No

Would you like to receive a text message for appointment reminders? Yes/ No
**If we can leave a text on your cell phone, what is your cell carrier? AT&T / Verizon / T-Mobile / Other: _____

WORKING STATUS

□ Full Duty □Disability □ Employed □ Unemployed □ Retired

Occupation: _____ **Employer:** _____

Primary Care Doctor: _____
Do we have your permission to contact your doctor regarding care in our office? Yes / No

Marital Status: Married / Single / Widowed / Divorced

Emergency Contact: _____ **Phone #:**_____

Preferred Language: English / Spanish / Other: _____

How did you hear about this program and/or the Doctor(s)? *(Please check one)*

Referred by:
□ My doctor
□ Internet □ Friend
□ T.V. □ Former patient: _____
□ Newspaper
□ Other _____ _____

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Signature: _____ Date: _____

PRIMARY COMPLAINTS: *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint
Write in your complaint(s) in order of importance. → →	**1.**	**2.**	**3.**	**4.**
Circle the word(s) that best describe the complaint.	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other
How often do you feel this complaint?	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"
How long have you had this complaint?	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better – Worse – Same	Better – Worse – Same	Better – Worse – Same	Better – Worse – Same
What makes it better, if anything?	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____
What makes it worse, if anything?	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life? *(all that apply)*	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

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1.) Is your main condition from an: □ Auto Accident Injury □ Job Injury □ Other: _____

How did your injury/condition occur? Was it sudden or a gradual occurrence? _____

2.) What have you tried at home to relieve the pain in the last 6 months? Check all that apply:

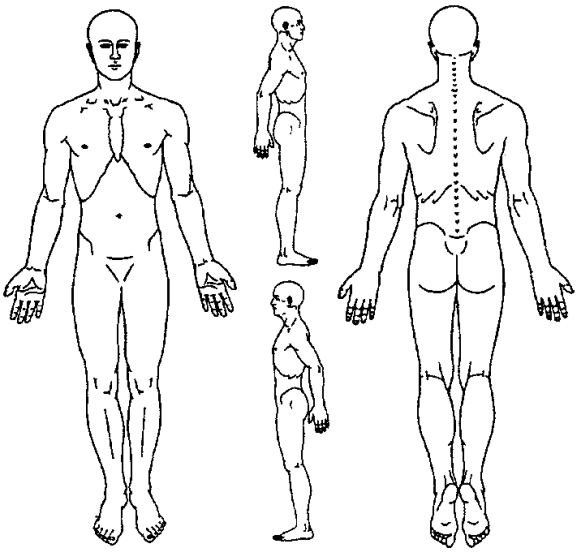
□ Tylenol □ NSAIDS/Ibuprofen □ Aspirin □ Heat □ Brace
□ Supplements □ Pain-relieving creams □ Stretches □ Ice pack □ **None**
□ Exercise □ Other: _____

3.) Have you tried any of the following? Check all that apply:

□ Massage □ Surgery □ Cortisone Injections - How long ago? _____
□ Narcotics □ Metanx □ Manipulations - How long ago? _____
□ Celebrex □ Neurontin □ Occupational therapy - How long ago? _____
□ Lyrica □ Home Exercises □ Physical therapy/Rehab - How long ago? _____
□ Tramadol □ Topical creams □ Epidurals - How long ago? _____
□ Cymbalta
□ Injections Series (i.e. *Euflexxa/Hyalgan/Supartz/Orthovisc/Synvisc/Gelsyn*)/Viscosupplementation for knees?
How long ago? _____

Patient Health History

Please circle your problematic areas on the body below.
Where are you experiencing your pain/discomfort?



4.) When was the last time you've seen a doctor for your condition(s)?

_____

Name of the doctor(s): _____

5.) List ANY surgeries and/or hospitalizations that you have had including their corresponding dates. □ NONE

_____

_____

6.) Please indicate which diagnostic tests you have had in the <u>past year</u> relating to your complaints:

□ X-ray □ EMG/NCV
□ CT Scan □ MRI
□ Discogram □ **None**

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7.) List any and all medications you are currently taking <u>including</u> over the counter and supplements:

MEDICATIONS	DOSE: (MG, MCG)	TIMES PER DAY	HOW LONG?
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			

PAST MEDICAL HISTORY

8.) Have you had any of the following? – Check all that apply:

		COMMENTS			COMMENTS
Bowel Disorders			**Polio**		
Cancer (Where)			**Psoriasis**		
Depression			**Rheumatism**		
Diabetes			**Seizures**		
Heart Disease			**Serious Infection**		
High Blood Pressure			**Stroke**		
Kidney Disease			**Surgery**		
Liver Disease			**Thyroid**		
Multiple Myeloma			**HIV+**		
Pacemaker			**Other**		

9.) ARE YOU ALLERGIC TO ANY MEDICATIONS and/or FOOD PRODUCTS?: □ Yes □ No **If yes, list below:**

Medication/Food:	Reaction:
Medication/Food:	Reaction:
Medication/Food:	Reaction:

Any additional comments that may help the doctor understand your condition?:

_____

I hereby authorize the Doctor/provider to treat my condition as he or she deems appropriate. The doctor will not be held accountable for any pre-existing medically diagnosed condition nor for any medical diagnosis. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I certify that the above information is true and correct. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.

_____	_____	_____
Patient's Signature	**Printed Name**	**Date**
_____	_____	_____
Consent to Treat a Minor Guardian's Signature	Printed Name	Date
_____	_____	_____
Guardian of Spouse's Signature for Authorizing Care	Printed Name	Date

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Signature: _____ Date: _____