Patient File # Date

Confidential Patient Health

Dr. Mr. Ms Mrs First: ______ Mid Initial: ______ Last ______

Birth Date: ___/___/___ Age: ______ Sex: Male / Female SSN: ______

Email Address: ______

Address: ______ Apt # ______

City: ______ State: ______ Zip: ______ County: ______

Home Phone: ( ) ______ Work Phone: ( ) ______ ext ______

Cell Phone: ( ) ______ Fax # ( ) ______

Single Married Widowed Divorced Separated Spouse's Name: ______

Children (Names & Ages) ______

Emergency Contact Name: ______ Phone: ( ) ______

INSURANCE INFORMATION

Who is responsible for your bill? YOU and. . .(mark appropriate box(es)) Myself ONLY Spouse

Worker's Comp Auto Insurance Medicare Other: ______

Health Ins: ______

Personal Health Insurance Carrier: ______ Member/ID Card# ______

Policy Holder's Name: ______ Group # ______

Policy Holder's Date of Birth: ___/___/___ Primary Care Physician: ______

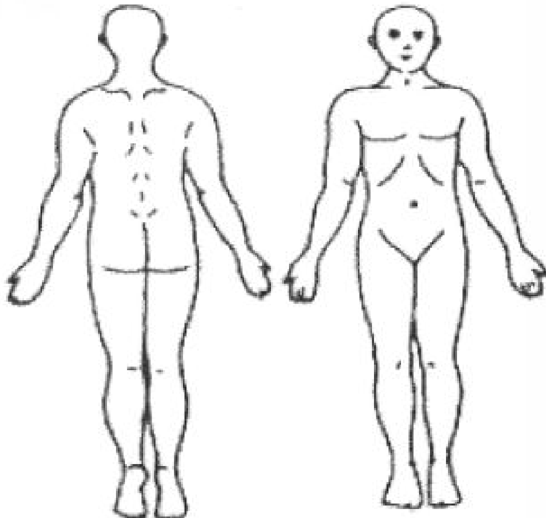
CURRENT HEALTH CONDITION

PLEASE LABEL THE DIAGRAM, AREA OF SYMPTOM:

Mark on figure below area of pain/numbness/burning.

Use Letters BELOW to indicate TYPE & LOCATION

A=Ache B=Burning N=Numbness P=Pins&Needles S=Stabbing



Unwanted Condition/Pain (Why are you here today?): ______

I currently have: ☐ PAIN ☐ STIFFNESS ☐ NUMBNESS ☐ WEAKNESS

Condition/Pain STARTED on what date? ______

Has it ever occurred before? Yes / No When? ______

Is this condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

EXPLAIN in your own words how the injury/pain/condition happened:

______

______

______

If caused by an Accident: Date ______ Time: ______

List **any other** Condition/Pain related or unrelated to the one listed above that you are experiencing: ______

______

Please rate your overall pain/unwanted condition/discomfort/stiffness on a scale of 0 to 10: