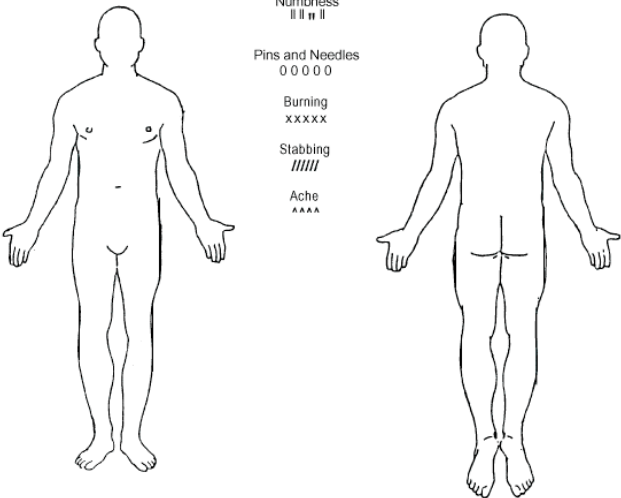


Confidential Patient Information

Name: _____ **Email:** _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Marital Status: _____ **Age:** _____ **Birth Date:** _____ **Social Security #:** _____
Occupation: _____ **Employer:** _____ **Phone (W):** _____
Work Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Spouse's Name: _____ **Occupation:** _____ **Employer:** _____
Spouse's Work Phone: _____ **Nearest Relative:** _____ **Phone:** _____
Name & Ages Of Children: _____ **Referred By:** _____
Primary Care Physician: _____ **Phone #:** _____
Insurance Name: _____ **Address:** _____
Second Insurance Name: _____ **Address:** _____

<p>If you are in pain, Please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain as well as any activity which brings on or aggravates your pain.</p> <div style="display: flex; align-items: center; justify-content: center;">  <div style="margin-left: 20px;"> <p>Numbness </p> <p>Pins and Needles 0 0 0 0 0</p> <p>Burning x x x x x</p> <p>Stabbing </p> <p>Ache A A A A</p> </div> </div> <p>Please mark the intensity of your pain along the line below</p> <p style="text-align: center;"> _____ 0 1 2 3 4 5 6 7 8 9 no pain worst pain </p> <p>Major Complaint: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How did this condition develop? (What caused it?) _____</p> <p>_____</p> <p>When did it start? _____</p> <p>Have you ever had this or a similar problem before? Y/N If yes explain: _____</p> <p>_____</p> <p>Have you ever received treatment for this condition? If yes, when, where and what were the results? _____</p> <p>_____</p> <p>Has your problem been getting better, worse, or staying the same? _____</p> <p>Is there anything that makes your condition worse? _____</p> <p>_____</p> <p>How has this condition affected your life? _____</p> <p>_____</p> <p>Home life : _____</p> <p>Work: _____</p> <p>Recreation: _____</p> <p>Rest and Sleep: _____</p> <p>Have you had any previous injuries accidents, falls that may have contributed to this condition? _____</p> <p>_____</p> <p>Any medical diagnosis of your complaint? _____</p> <p>_____</p> <p>Drug you now take: Muscle relaxant[] Pain Killer [] Stimulants[] Insulin [] Birth control [] Nerve [] Other: _____</p>
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Please continue this form on the reverse side

Have you ever been in an automobile accident? Y/N When? _____

Describe your injuries: _____

Any allergic reactions to medications? _____

Date of last menses? _____ Are you pregnant? _____

Please give your history of any past major illness or surgery. (Include date and area of the body affected.)

Please give history of all X-rays or other diagnostic imaging studies (other than dental) taken: _____

Do you eat balanced meals ? _____ Do you take vitamin supplements? _____ What type? _____

Do you have a regular exercise program? (List type and frequency) _____

Do you smoke? Y / N Amount per week? _____ Do you drink alcoholic beverages? Y / N Amount per week? _____

Are you currently using any back or arch supports, heel lifts, orthotics or any braces of any kind? Y / N Describe: _____

<p>Past & Present Medical History Check if you now have or were ever treated for the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Broken Bones <input type="checkbox"/> Diabetes <input type="checkbox"/> Liver problems <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Glaucoma <input type="checkbox"/> Ulcers <input type="checkbox"/> Nervous condition <input type="checkbox"/> Allergies <input type="checkbox"/> Previous foot condition <input type="checkbox"/> Back problem <input type="checkbox"/> Neck problem <p>Notes: _____ _____ _____</p> <p>Check if any of the following symptoms are present at this time:</p> <p>Head</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Trauma <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Other 	<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glasses <input type="checkbox"/> Pain <input type="checkbox"/> Spots <input type="checkbox"/> Double vision <input type="checkbox"/> Other 	<p>Heart & Lungs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Coughing <input type="checkbox"/> Sputum production <input type="checkbox"/> Chest noises <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Other 	
	<p>Ears</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Ringing/ noises <input type="checkbox"/> Hearing loss <input type="checkbox"/> Loss of balance <input type="checkbox"/> Other 	<p>Menstrual / Obstetrical</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cramps <input type="checkbox"/> Difficult deliveries <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Breast lump <input type="checkbox"/> Other 	<p>Dr Notes CC: _____ _____ _____</p>
	<p>Muscle & Joints</p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Grinding/ popping <input type="checkbox"/> Loss of Flexibility <input type="checkbox"/> Other 	<p>Nervous System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling (pins & needles) <input type="checkbox"/> Nervousness <input type="checkbox"/> Coordination problems <input type="checkbox"/> Convulsions <input type="checkbox"/> Other 	<p>Onset _____ Provocative _____ Palliative _____ Quality _____</p>
	<p>Abdominal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Gas <input type="checkbox"/> Burning <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Diarrhea/ Constipation 	<p>Radiation _____ Severity _____ Time _____ Relation to other areas _____ Notes _____ _____ _____</p>	