

PATIENT – PLEASE FILL OUT INFORMATION BELOW

This information will assist us in your treatment. If you have difficulty answering these questions, please speak with a member of my staff at the time of your visit.

Name: _____ Today's Date: _____ Age : _____

Address: _____ City/State/Zip: _____

Phone: _____ Social Security #: _____ Date of Birth: _____

I was referred by _____ M.D. Dr.'s. Phone: _____

Current Complaint & History

1. What is the reason for this visit?

- Chief concern/symptoms: _____
2. When did you first become aware of this problem? _____
3. Describe the duration and course of the problem (continuous, intermittent, etc.) _____
4. What part of your body is most affected? _____
5. Have you noticed other changes in bodily function, which developed around the time of your present problem? (Y/N)
If so, specify: _____
- 6.. Is there anything that makes your problem better (medication, rest, etc.)? _____
7. Is there anything that makes your problem worse (exercise, lack of sleep, certain foods, etc.)? _____
8. Have you previously received a diagnosis for this problem? (Y/N) _____
If so, please specify: _____
Have you had a muscle or nerve biopsy? (Y/N) _____ If so, when and where?

9. Have you received treatment for this problem? (Y/N) _____
If so, please specify what treatment and when: _____
10. If you answered "Yes" to questions 9 and/or 10, please provide the attending physician's name and address:
11. Has your problem interfered with your activities of daily living (bathing, feeding, or clothing yourself)? _____

12. Has your problem interfered with your occupation? _____
13. Does anyone in your family have a similar problem? _____
14. Is anyone in your family known to have a neurological disease? (Y/N) _____
 If so, please specify:

Past Medical History (Patient)

Please check the appropriate answers and/or conditions

- | | | | |
|-----------------|--|------------------------------------|------------------------------|
| Adult Illnesses | _____ Anemia (Low blood) | _____ Asthma (Wheezing) | _____ Bleeding tendencies |
| | _____ Blood clotting disorder | _____ Bronchitis | _____ Cancer |
| | _____ Diabetes | _____ Emphysema | _____ Heart Disease |
| | _____ Hypertension (high blood pressure) | _____ Bladder Disease | _____ Glaucoma |
| | _____ Gallbladder Disease | _____ Influenza | _____ Tuberculosis |
| | _____ Hepatitis (liver infection) | _____ Thyroid Disease | _____ Jaundice (yellow skin) |
| | _____ Arthritis | _____ Kidney disease or stones | _____ Mental Illness |
| | _____ Skin lesions or rashes | _____ Sexually transmitted disease | |
| | _____ Cataracts | | Other: _____ |

Current Weight: _____

Operations/Hospitalizations List dates and diagnoses:

Major accidents/Injuries: List dates and types _____

List all prescriptions and over-the-counter medications you are currently taking, and be sure to bring all medication bottles *with* you to your office visit.

Are you currently taking any herbal medicines or "health foods"? _____

Allergies: List all allergies or unusual reactions to any medications. _____

Habits:	Present	Past	How Much
Tobacco,	_____ Y/N	_____ Y/N	___/Day
Alcohol	_____ Y/N	_____ Y/N	___/Day
Exercise	_____ Y/N	_____ Y/N	
Drug Use	_____ Y/N	_____ Y/N	

Family History: Please check if anyone in your family now has or has ever had any of the following conditions:

- | | | | | |
|----------------|---------------------------|----------------------|--------------|----------------------|
| _____ Diabetes | _____ High Blood Pressure | _____ Heart Problems | _____ Asthma | _____ Kidney Disease |
| _____ Cancer | _____ Thyroid Disease | _____ Other: | | |

Relationship of this family member to you: _____

Job History: List all occupations, past and present, and any possible exposure to potentially toxic chemicals or gasses. _____

Review of Medical Systems

Please check any of the following statements and/or symptoms, which apply to you:

General: ___ Good health most of the time ___ Ill occasionally ___ Frequently ill
 ___ Easily fatigued ___ Fatigued only after exercise ___ Fatigued upon awakening
 ___ Fatigued all the time ___ Excessive weight gain ___ Excessive wt.loss (Specify: ___lbs. In ___days)

Skin: Change in: ___ Color ___ Moisture ___ Texture (dry or oily)
 Do you have: ___ Lesions ___ masses ___ Easy bruising
 ___ Bleeding ___ Itching ___ Scaling

Hair: Do you have: ___ Loss ___ Excessive growth ___ Change in Texture or distribution

Glands: ___ Enlargement ___ Pain ___ Drainage

Blood: ___ Leukemia ___ Anemia (Low Blood) ___ Bleeding Disorders

Other: _____

Endocrine: ___ Abnormal Growth or body configuration, excessive- sweating, unusual sensitivity or insensitivity to hot or cold
 ___ Increased thirst, urination, or hunger?
 ___ Infertility, or any known hormonal abnormality?
 ___ Any known thyroid problem ?

Eyes: ___ Loss of vision ___ Trauma ___ Color Blindness
 ___ Infection ___ Retinopathy ___ Retinal Detachment

Ears: ___ Pain ___ Infection ___ Loss of or decrease in hearing
 ___ Trauma ___ Ringing in the ears

Nose: ___ Trauma ___ Runny nose ___ Nose bleeds
 ___ Frequent nasal/sinus infection

Mouth: ___ Trauma ___ Difficulty Chewing ___ Pain
 ___ Infection ___ Excessive Tongue Movement ___ Excessive Salivation

Throat ___ Hoarseness ___ Trauma ___ Frequent Sore Throat
 ___ Change in voice ___ Pain or Difficulty swallowing

Neck: ___ Swelling ___ Stiffness ___ Weakness
 ___ Pain ___ Trauma ___ Limitation of movement

Breasts: ___ Change in size ___ Lumps ___ Nipple discharge
 ___ Skin lesions ___ Change in skin color

Respiratory: ___ Wheezing ___ Coughing ___ Asthma
 ___ Tuberculosis ___ Night Sweats ___ Sputum production (coughing up mucus)
 ___ Shortness of breath at rest
 ___ Shortness of breath after walking ___ blocks
 ___ Other lung infection: _____

Cardiovascular: ___ Angina (chest pain) ___ Irregular heart rat/rhythm

<input type="checkbox"/> Palpitations	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Pain in legs after walking	<input type="checkbox"/> Cold hands and/or feet
<input type="checkbox"/> Shortness of breath after exercise	<input type="checkbox"/> Swelling of hands and/or feet
<input type="checkbox"/> Shortness of breath at night before falling asleep	<input type="checkbox"/> Shortness of breath at night which awakens you from sleep

Gastrointestinal:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Abdomen Pain	<input type="checkbox"/> Change in appetite
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Change in bowel movements	<input type="checkbox"/> Gas
<input type="checkbox"/> Jaundice (Yellow skin)	<input type="checkbox"/> Difficult or painful swallowing	<input type="checkbox"/> Decreased urination
<input type="checkbox"/> Change in color of urine	<input type="checkbox"/> Increased urination	<input type="checkbox"/> Change in menstrual cycle
<input type="checkbox"/> Difficult or painful urination	<input type="checkbox"/> Frequent urination at night	

Neurological:

1. Memory loss or decline Mood swings
 Personality changes Depression
 Excessive crying or laughing Decreased or poor concentration
 Difficulty finding words Poor understanding of words

2. Poor or decline in vision Double vision
 Drooping eyelid or difficulty closing or opening eye Decreased hearing
 Change in speech (slurring or hoarseness) Difficulty swallowing

3. Weakness in left arm right arm left leg right leg neck
 Difficulty walking Increased number of falls
 Difficulty standing from a sitting position Muscle pain or tenderness
 Change in muscle size smaller larger
 Involuntary movement (shaking, twitching, or spasms)
 Decreased or poor balance

4. Seizures Dizziness
 Headaches Blackouts
 Light-headedness upon standing Inability to sleep
 Excessive sleeping

5. Decreased sensation location _____
 Pain location _____

ADDITIONAL COMMENTS:

REVIEWED BY: _____

Please fill this out for our billing and administrative departments even if you gave this information on the preceding sheets:

PATIENT NAME: LAST:	FIRST:
STREET ADDRESS:	
CITY/ST/ZIP:	

DATE OF BIRTH: _____ Age: _____ SSN: _____

TELEPHONE NUMBER: _____

WORK NUMBER: _____

CELL OR ANY OTHER CONTACT NUMBER: _____

REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN'S PHONE _____ Fax: _____

ADDRESS _____ CITY/State/ZIP _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY/State/ZIP _____

INSURANCE COMPANY'S PHONE NUMBER: _____

PLEASE MARK TYPE FOR PRIMARY:

HMO PPO POS INDEMNITY MEDICAID MEDICARE CPO

IS THE PATIENT THE INSURED? _____

IF NOT, NAME OF THE INSURED: _____

DATE OF BIRTH OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER _____

GROUP OR POLICY NUMBER: _____

PLEASE MARK TYPE FOR SECONDARY:

HMO PPO POS INDEMNITY MEDICAID MEDICARE CPO

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY/State/ZIP _____

INSURANCE COMPANY'S PHONE NUMBER: _____

IS THE PATIENT THE INSURED? _____

IF NOT, NAME OF THE INSURED: _____

DATE OF BIRTH OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER _____

GROUP OR POLICY NUMBER: _____

IS THIS WORKER'S COMP? YES NO (Note: We do not see worker's comp patients)