PERSONAL HISTORY

Date:Name: Name: City: Home Phone No: Occupation: Birthdate: Age: Circle one: Single Married Divorced Separated	Social Security No. :
Name and No. of Emergency contact:	
Who is responsible for your bill: \Box Self \Box Personal Health	Insurance 🗆 Medicare 🗆 Worker's Comp. 🗆 No Fault
If Insurance, Name of Insurance Company	Insured?
Policy / ID No.:	
CURRENT HEAL	
Purpose of this appointment:	
List extent of injury:	
Where & when did this condition begin?	
Drugs you NOW take Nerve pills Allergy pills Insulin Pain killers/Muscle relaxers Blood pressure Birth cont	
Other: Do you suffer from any condition other than which you are now consulting us? Other doctors consulted? Current or previous major surgery/operations:	
□ Broken bones □ Appendectomy □ Tonsillectomy □ Herr □Other:	
WORKERS COMPENSATION QUESTIONNAIRE Name & Address of Employer:	Explain in detail how the injury or accident occurred
Contact person:	

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Appendicitis	Malaria	Chicken pox	Alcoholism
Scarlet fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping cough	Cancer	Arthritis
Typhoid fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic fever	Mumps	Influenza	COVID
Polio	Small pox	Pleurisy	Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS.

If symptoms are from an ACCIDENT, Mark with an A:

MUSCULO-SKELETAL CODE	GASTRO-INTESTINAL CODE		
Head too heavy	Poor excessive appetite	Heart problem	
Low back pain	Excessive thirst	Lung problems	
Pain between shoulders	Frequent nausea	Congestion	
Neck pain	Vomiting	Varicose veins	
Arm pain	Diarrhea	Ankle swelling	
Joint pain/stiffness	Constipation	Asthma	
Walking problems	Hemorrhoids		
Difficult chewing/clicking jaw	Liver problem	EENT CODE	
Painful tailbone	Gall Bladder problems	Loss of balance	
Spinal curvature	Weight problem	Loss of taste	
Faulty posture	Abdominal cramps	Vision problems	
	Gas/bloating after meals	Dental problems	
NERVOUS SYSTEM CODE	Heartburn	Sore throat	
Pins & needles arms	Black/bloody stool	Ear aches	
Pins & needles legs	Colitis	Hearing difficulty	
Numbness		Stuffed nose	
Paralysis	GENITO-URINARY CODE	Ringing in ears	
Dizziness	Bladder trouble	Nose bleeds	
Forgetfulness	Painful/excessive urination	Post nasal drip	
Confusion/Depression	Discolored urine	Sinus trouble	

- _Confusion/Depression
- _Cold/tingling extremities
- ____Fainting
- _Convulsions

GENERAL CODE

Allergies	Anxiety
Cold sweats	Fatigue
Loss of sleep	Headaches

FAMILY HISTORY

__Irregular heartbeat

Bedwetting

C•V•R CODE

Chest pain Short Breath

____Inability to control urine

Blood pressure problems

	Diabetes	Cancer	Heart	Back
Mother				
Father				
Brother No. of				
Sister No. of				

FEMALE/MALE CODE

____Loss of smell

Menstrual irregularity
Menstrual cramping
Vaginal pain/infection
Breast pain/infection
Prostate/Sexual dysfunction