

Chinatown Physical Medicine & Rehab, Ltd.
Confidential Patient Information >>> PLEASE PRINT

Date: _____ Email address: _____

Name: _____

Name of Wife, Husband, or Guardian _____

Their phone number: () _____

Your current address: _____

City: _____ State: _____ Zip Code: _____

Home number: () _____

Cell number: () _____

Work number: () _____ Extension: _____

Social security number: _____

Birthdate: _____ Age: _____ Sex: Male / Female

Marital Status: Single / Married / Widowed / Divorced / Separated

Are you a student? No / Part-time / Full-time

Occupation: _____ (Full-time / part-time / temp)

Employer's name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of Emergency Contact: _____

Their phone number: () _____ Relationship: _____

Names & ages of your children: _____

How did you hear about our office?

YellowBook: _____ Patient: _____

Internet site: _____ Other: _____

List Chiropractors you have seen before:

1. Name: _____ Last visited on: _____ X-rays? yes / no

2. Name: _____ Last visited on: _____ X-rays? yes / no

List Medical Doctors consulted within the past year:

1. Name: _____ Reason for visit? _____

2. Name: _____ Reason for visit? _____

Please list all your reasons for visiting our office:

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

List **ALL** Medications you take. (Prescriptions & over-the-counter- use add'l pages if needed)

| Drug name: | Dosage: | How long have you taken this & for what condition? |
|------------|---------|--|
| | | |
| | | |
| | | |

List **ALL** Nutritional supplements you take. (Use add'l pages if needed)

| Name of supplement(s) | Dosage: | How long have you taken this & for what condition? |
|-----------------------|---------|--|
| | | |
| | | |
| | | |

List **ALL** previous hospitalizations, surgeries, accidents, falls, fractures & illnesses

Example: **ALL** PAST Auto, Sports, Work, Home-Related). Use add'l pages if needed.

| | | | | | | |
|---------|-------|------|-------|---------------|-----|----|
| 1. Type | _____ | When | _____ | Hospitalized? | Yes | No |
| 2. Type | _____ | When | _____ | Hospitalized? | Yes | No |
| 3. Type | _____ | When | _____ | Hospitalized? | Yes | No |
| 4. Type | _____ | When | _____ | Hospitalized? | Yes | No |

Do you consume any of the following? (leave blank what doesn't apply)

| | | | |
|------------------------------|-------|-----------------------|-------|
| Tobacco products (packs/day) | _____ | How many years? | _____ |
| Coffee/tea cups/day | _____ | Caffeinated or Decaf? | _____ |
| Use artificial sweeteners? | _____ | If so, please list | _____ |
| Alcohol drinks/day? | _____ | How many years? | _____ |
| Soft drinks (soda)/ day? | _____ | Regular or diet? | _____ |

Level of exercise? None Moderate (days/wk) _____ Strenuous (days/wk) _____

What type of exercise (s): _____

Have you experienced any **unexplained or rapid** weight changes in the last six months?

Please circle: No Yes if yes, list pounds _____ lost / gained

Circle any of the following diseases you have had:

| | | | |
|-----------------|-------------|-----------------|----------------|
| Pneumonia | Mumps | Influenza | Anemia |
| Pneumatic Fever | Small pox | Pleurisy | Measles |
| Polio | Chicken pox | Arthritis | Heart diseases |
| Tuberculosis | Diabetes | Epilepsy | Thyroid |
| Whooping cough | Cancer | Mental disorder | Eczema |

Circle any of the following you have had the past **6** Months

Musculo-skeletal:

Neck pain
Pain between shoulders
Arm pain
Difficulty chewing/clicking jaw
Midback pain
Lowback pain
Joint pain/stiffness
Difficulty walking

Gastro-Intestinal:

Poor/excessive appetite
Excessive thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids

Nervous system:

Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/depression
Fainting
Convulsions
Cold/tingling extremities
Stress

Genito-Urinary:

Bladder trouble
Painful/excessive Urination
Discolored Urine

C-V-R

Chest pain
Shortness of breath
Blood pressure problems
Irregular heartbeat
Heart problems
Lung problems/congestion
Varicose veins
Ankle swellings
Stroke

EENT:

Vision problems
Dental problems
Sore throat
Ear aches
Hearing difficulty
Stuffed Nose

Gastro-Intestinal cont.:

Liver Problems
Gall bladder problems
Abdominal cramps
Gas/bloating after meals
Heartburn
Black/bloody stool
Colitis

General:

Fatigue
Allergies
Loss of sleep
Fever
Headaches

Male/Female:

Menstrual Irregularity
Menstrual cramps
Vaginal pain/infection
Breast pain/lumps
Prostate/Sexual dysfunction

Please write which conditions your family has experienced from the list below.
(Alzheimer's, Cancer, Diabetes, Heart Disease, Parkinson's, MS, &/or Stroke)

Mother: _____
Father: _____
Grandmother: _____
Grandfather: _____
Grandmother: _____
Grandfather: _____
Sister(s): _____
Brother(s): _____
Children: _____

Type of care desired (please circle): RELIEF CORRECTIVE

I understand that the practice of chiropractic or medicine is not an exact science and that your care may involve the making of judgements based upon the facts know to the Doctor(s) at that time; therefore it is not responsible to expect the doctors to be able to anticipate or explain all risks and complications;that an undesirable result does not necessarily indicate error in judgement during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I, the undersigned, hereby authorize the staff at Chinatown Physical Medicine & Rehab, Ltd to perform such services as deemed necessary by the physician(s) to diagnose and treat my condition(s).

I authorize assignment of my insurance rights and benefits directly to this provider in order to pay for my medical bills. I also authorize the release of such information as is needed to process insurance claims by provider or agent.

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 also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due & payable to CPMR Ltd. I hereby authorize the Doctor(s) to treat my condition as he or she deems appropriate. It is understood & agreed that the amount paid to the Doctor for x-rays, is for examination only & the x-ray negatives will remain property of this office, being on file where they can be seen at a reasonable time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Date: _____
Date: _____
Date: _____

Patient's Signature: _____
Consent to treat a minor: _____
Signature of Guardian authorizing care: _____

Complaint History

Complaint # _____

When did your complaint first begin? _____

Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/symptom you experience: _____

Does your problem travel into any other part of your body? If so, where? _____

Where exactly is the complaint area? _____

When do you notice the problem? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..?) _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe & 10 being bedridden: _____

Add'l Notes: _____

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