

PATIENT INFORMATION

TODAY'S DATE _____ DOCTOR _____

NAME _____

LAST FIRST MIDDLE
ADDRESS _____HOME PHONE _____ - _____ - _____ WORK PHONE _____ - _____ - _____
AREA EXT. ZIP CODE

CELL PHONE _____ - _____ - _____ SOCIAL SECURITY# _____ - _____ - _____

E. MAIL ADDRESS _____

DATE OF BIRTH ___ / ___ / ___ AGE _____

EMPLOYER NAME _____

ADDRESS _____
NUMBER STREET CITY STATE ZIP

OCCUPATION _____

PERSON TO CONTACT IN CASE OF EMERGENCY
NAME _____
PHONE _____

DATE OF ACCIDENT/INJURY _____

HEALTH INSURANCE AUTO INSURANCE
COMPANY NAME _____ COMPANY _____
ADDRESS _____ ADDRESS _____

ID NUMBER _____ CLAIM NUMBER _____

SECONDARY OTHER PARTY
COMPANY NAME _____ COMPANY _____
ADDRESS _____ ADDRESS _____
ID NUMBER _____ CLAIM NUMBER _____

If you do not have health or auto insurance, please sign below.

SIGNATURE _____ DATE _____

Medications – Please list ALL current medications
(Include aspirin, Coumadin, Herbal medication, diet pills, cold tablets, etc.)

Medicine	Strength	How many?	How often?

Allergies

Medicine	List Medicine i.e. Penicillin	Reaction(s) i.e. Rash
To Other Things	List Other Allergy i.e. Mold, Detergents...	Reaction(s) i.e. Sneezing, runny nose...

Review of Symptoms (Please check all conditions which apply currently):

Constitutional Symptoms

- Fever
- Weight loss/gain
- Fatigue

HEENT

- Headaches
- Blurred Vision
- Glaucoma
- Glasses
- Light Sensitivity
- Hearing Difficulty/Aid
- Ear pain
- Congestion
- Bleeding
- Sinus Infection
- Dentures
- Jaw/Tooth Pain
- Mouth Sores
- Sore Throat
- Hoarseness

Cardiovascular

- High Blood Pressure
- Chest Pain
- Abnormal Heart Rhythm
- Swelling of Ankles
- Pacemaker
- Blood Clot
- Use of Blood Thinners

Respiratory

- Painful Breathing
- Productive Cough
- Bronchitis
- Pneumonia
- Shortness of Breath

Gastrointestinal

- Abdominal Pain
- Heartburn
- Hiatal Hernia
- Nausea & Vomiting
- Constipation & Diarrhea
- Ulcers
- Liver/Gallbladder Problems
- Black, Bloody Stools

Genitourinary

- Painful Urination
- Bladder Infection
- Difficult Urination
- Frequent Urination
- Blood in Urine
- Sexually Transmitted Disease

Musculoskeletal

- Arthritis
- Bursitis
- Pain/Numbness
- Shoulder
- Arms
- Hands
- Elbows
- Neck
- Hip
- Legs
- Knees
- Feet
- Tailbone
- Poor Posture

Integumentary (skin or breast)

- Rash
- Itching
- Bruise easily
- Shingles
- Skin Cancer

Neurological

- Tremors
- Weakness/Numbness/Tingling
- Dizziness
- Loss of Coordination

Psychiatric

- Memory Loss
- Alzheimer's
- Depression
- Anxiety
- Alcoholism
- Thoughts of Suicide
- Irritability

Allergic/Immunologic

- Hay Fever
- Allergies (other than drugs)
- AIDS/HIV
- Cancer

Women Only

- Breast Pain
- Cramps or Backache
- Heavy Menstruation
- Hot Flashes
- Irregular Cycle
- Lumps in Breast
- Menopause
- Painful Menstruation
- Vaginal Discharge
- Pain on Intercourse

Previous Tests For This Condition

<input type="checkbox"/> NONE (Go to next section below)	How Many	When (Month/Year)	What Facility (Clinic/Hospital)	Results (As given to you)
<input type="checkbox"/> Regular x-rays				
<input type="checkbox"/> CT Scan				
<input type="checkbox"/> MRI Scan				
<input type="checkbox"/> Discogram				
<input type="checkbox"/> Injections <input type="checkbox"/> Epidural <input type="checkbox"/> SI Joint <input type="checkbox"/> Facet <input type="checkbox"/> Other _____				
<input type="checkbox"/> CT Myelogram				
<input type="checkbox"/> Nerve Tests (EMG/NCV)				
<input type="checkbox"/> Other: _____				

Previous Treatments For This Condition

<input type="checkbox"/> NONE (Go to next section below)				
MEDICATIONS:	Name if Known	No Help	Some Relief	Good Relief
<input type="checkbox"/> Anti-inflammatory				
<input type="checkbox"/> Muscle Relaxants				
<input type="checkbox"/> Pain Medications				
<input type="checkbox"/> Other: _____				
THERAPIES:				
<input type="checkbox"/> Chiropractic Care/Manipulation				
<input type="checkbox"/> Physical Therapy/Rehabilitation				
<input type="checkbox"/> Psychological Consult				
<input type="checkbox"/> Other: _____				

Spinal Surgery (List Type, Level, Approximate date and surgeon):

Previous treating doctors: _____

Specialty(ies) i.e. Surgeon: _____

Family Medical History

Mother: Alive Age _____ Good Health Suffers _____
 Deceased Age _____ Cause of Death: _____

Father: Alive Age _____ Good Health Suffers _____
 Deceased Age _____ Cause of Death: _____

Members of family (brothers, sisters, grandparents, aunts and uncles) suffer with the following:

Medical Problem	Relationship	Medical Problem	Relationship
<input type="checkbox"/> NONE: (Go to next section below)		<input type="checkbox"/> Heart Trouble	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Back Problems	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lung Disease		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Don't Know	

Social History

To provide a safe environment for all our patients, we ask this question to all patients. Are you in a relationship with someone who makes you feel afraid, is hurting you, forcing sexual contact or trying to control you life or making you feel unsafe? (Optional)

No Yes

Married Separated Divorced Widow/widower Single

Ability to enjoy life: Excellent Very good Good Fair Poor

My pain has affected my ability to perform my job or acquire a job: Yes No

The changes in my lifestyle due to my problem have been difficult for me: Yes No

Where do you live? (i.e. two-story home, assisted living home): _____

Number of children: Living at home _____ Away _____ Other dependents: _____

Currently Employed Occupation: _____ Previous occupation: _____

Retired Occupation(s) prior to retirement: _____

Highest educational level attained: Grammar High School College Post Graduate

Do you have special needs? Yes No Explain: _____

Alcohol Use: None Beer Wine "Hard" Drinks
Frequency: Rarely Socially Daily

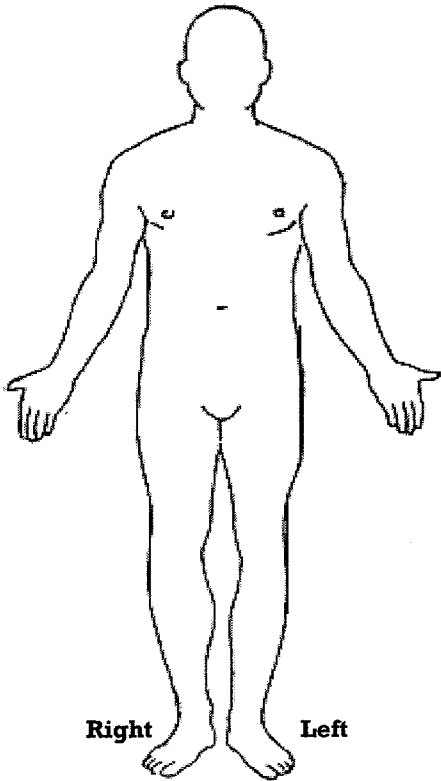
Tobacco Use: None Cigarettes Cigar/Pipe Smokeless/leaf
Frequency: How many per day? _____ How many years? _____
 I quit!! When: _____

THANK YOU!

Patient Pain

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.



Right Left

Front

Numbness



Pins & needles



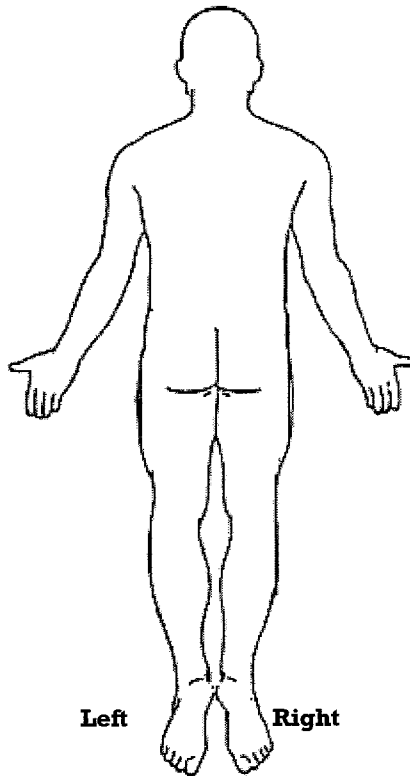
Burning



Stabbing



Ache



Left Right

Back

Please put one mark on the thermometer to show how bad your usual pain is these days.



10 (My pain is as bad as it could possibly be.)

1 (I have no pain at all.)

Chief/Primary Complaint

Explain how your pain or problem began:

- "I don't know how it began"
- It is recurrent – it comes and goes
- Recent injury/trauma
- On-the-job injury
- Off work due to this recent problem?
- Yes No How long? _____
- Old injury ("I've had it a long time")
- Approximate date: _____
- Previous occurrence(s): No 1-4 previous occurrences more than 4 times



PATIENT INFORMATION

SportsMedicine

Dr. Anthony J. Miller
Chiropractic Physician

Permission for Treatment

During the course of my treatment at **Esquire Sports Medicine**, I understand that I will be seen, evaluated, and treated by a qualified healthcare professional.

Patient Name (Please Print)

Signature of Patient

If the patient is a minor or under legal guardianship by my signature as a guardian, I authorize evaluation and medically necessary tests and treatment.

Signature of Parent or other legally responsible person (Parent/Guardian)

Date/Time



Reason For Visit

Due to patient time slots, multiple problems may require more than one visit for evaluation.

AGE: _____

DATE OF INJURY/PROBLEM: _____

Primary reason for this visit is:

(Please choose those that apply):

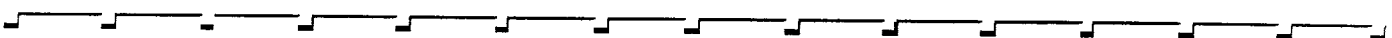
Pain location:

- RIGHT
- LEFT
- BILATERAL

- Low Back
- Hip/Buttock/Groin
- Thigh/upper leg
- Knee /lower leg
- Ankle/Foot/Toes
- Middle Back
- Other (list) _____

- Neck
- Shoulder
- Upper Back
- Arm/Elbow/Forearm
- Hand/Wrist/Fingers
- Face/Head

- Joint pain (list)
 - o _____
- Muscle pain (list)
 - o _____
- Total Body pain



Before you continue...

We know that filling out all of these forms can be annoying – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you the best medical care possible. All information will be kept strictly confidential. Thank you for your cooperation.

Who may we thank for your referral?: _____

What do you want to happen as a result of this visit?

Is there something you want to stress that is important? Yes No
