CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:_____ Date of Birth_____

Name: _____

Address_____ City_____ State_____Zip_____

Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age _____

SS#_____ Male Female Drivers License # _____

Marital Status: Married Single Divorced Separated Other

_____

Mother's Name if minor_____ Father's Name if minor_____

Name of Individual to contact in case of emergency: _____Phone : _____

Number of Children: ____ Names and ages of children: _____

Your Occupation: _____ Your Employer _____

Employer's Address_____ Employer's Number _(____)_____

Weight Frequently Required to lift is Under 10 20 30 40 Lbs: _____

Referred to this office by: TV Screening Where?

_____

AT&T Yellow Pages Healthbeat WECT WWAY Clinic Location Star News Letter

Health Journal Post Card Radio Flyer Attorney Phone Call

Friend – Name? _____ MD – Name? _____ Other_____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY

1. _____ Date _____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY

Job Auto Other: 1. _____

Date_____

Job Auto Other: 2. _____

Date_____

Job Auto Other: 3. _____

Date_____

What type of care are you looking for? Temporary Relief Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. _____
2. _____
3. _____
4. _____

THIS PROBLEM IS: RAPIDLY IMPROVING SLOWLY IMPROVING GRADUALLY WORSENING

FLUCTUATES BUT GETTING BETTER REMAINS THE SAME RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE Morning Afternoon Evening

WHEN AND HOW OCCURRED? _____

_____

SYMPTOMS DEVELOPED FROM: ☐ ILLNESS ☐ UNKNOWN CAUSE

☐GRADUAL ONSET DATE OCURRED: _____

SYMPTOMS HAVE PERSISTED FOR #_____HOUR(S) _____DAY(S)_____WEEK(S)_____MONTH(S)_____YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES WHEN? _____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?:

☐ ADD/ADHD ☐ DYSLEXIA ☐ AUTISM ☐ ASPERGER'S SYNDROME

☐ LEARNING DISABILITY ☐ INSOMNIA ☐ OTHER _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐NO ☐YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS? ☐NO ☐YES WHAT KIND? _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

☐READING ☐STUDYING ☐WORKING IN GROUPS ☐WATCHING TV ☐ PLAYING VIDEO GAMES

☐CERTAIN FOODS _____ ☐ Other _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

☐MEDICATION ☐RELAXING ☐PLAYING VIDEO GAMES ☐EXERCISE ☐LAYING DOWN

☐WATCHING TV ☐Other _____

PLEASE CHECK ANY ADDITONAL SYMPTOMS YOU MAY BE EXPERIENCING

☐BLURRED VISION ☐BUZZING IN EARS ☐COLD FEET ☐COLD HANDS ☐DAY DREAM

☐CONCENTRATION LOSS/CONFUSION ☐CONSTIPATION ☐DEPRESSION ☐DIARRHEA

☐DIZZINESS ☐FACE FLUSHED ☐FAINTING ☐FATIGUE ☐FIDGETY

☐SHORT ATTENTION SPAN ☐HEADACHES ☐INSOMNIA ☐LIGHT BOTHERS EYES

☐LOSS OF BALANCE ☐LOSS OF SMELL ☐LOSS OF TASTE ☐EASILY COLD ☐STIFF NECK

☐SHORT TEMPER ☐NUMBNESS IN FINGERS ☐NUMBNESS IN TOES

☐RINGING IN EARS ☐SHORTNESS OF BREATH ☐STOMACH UPSET

☐PINS AND NEEDLES IN ARMS ☐PINS AND NEEDLES IN LEGS

PLEASE EXPLAIN WHAT YOU HAVE DONE TO TRY TO FIX THE PROBLEM.

_____

_____

_____

_____

HAVE ALL OF THESE TREATMENTS FAILED TO FIX YOUR PROBLEM? ____ YES ____ NO

HOW HAS THIS PROBLEM AFFECTED YOUR DAILY ACTIVITIES?

_____

_____

_____

_____

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Drs. Graf, Richardet, and Bailey (and appointed staff) to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.
I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature _____ Date _____