Confidential Patient Information – 4 pages

Your First Name: | MI | Last Name: | ☐ Male ☐ Female | Date of Birth: | Age: | Social Security Number:

Your Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Number of Children**:

Insured First Name: | MI | Last Name: | ☐ Male ☐ Female | Date of Birth: | Age: | Social Security Number:

Your Home Address: City: State: Zip:

Home Phone Number: **Work Phone Number:** **E-mail Address:**

Employer Name: Your Job title/Occupation: Years employed:

Work Address: City: State: Zip:

Health Questionnaire and Overview

If you have ever had a symptom in the past, please list that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present Column.

~KNOWLEDGE OF ANY OF THE FOLLOWING INFORMATION MAY INFLUENCE THE TYPE OF TREATMENT/ THERAPY YOU RECEIVE~

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R___ L___)
☐	☐	Pain in Upper Arm or Elbow (R___ L___)
☐	☐	Hand Pain (R___ L___)
☐	☐	Wrist Pain (R___ L___)
☐	☐	Upper Back Pain (R___L____)
☐	☐	Lower Back Pain (R___L____)
☐	☐	Pain in Upper Leg or Hip (R___ L___)
☐	☐	Pain in Lower Leg or Knee (R___L____)
☐	☐	Pain in Ankle or Foot (R___ L___)
☐	☐	Jaw Pain (R___ L___)
☐	☐	Headache
☐	☐	Swelling, Stiffness of Joint(s)

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Aortic Aneurysm
☐	☐	Heart Attack (Date:_____)
☐	☐	Stroke (Date:_____)
☐	☐	Asthma
☐	☐	Cancer, Explain _____
☐	☐	Prostate Disorders, Explain _____
☐	☐	Blood Disorder
☐	☐	Emphysema (Chronic Lung Disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes, Type:_____
☐	☐	Ulcer
☐	☐	Liver/Gallbladder Conditions
☐	☐	Hepatitis, Type:_____
☐	☐	Bladder Infection
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS

Past	Present	Condition
☐	☐	Fainting, Visual Disturbances, Dizziness
☐	☐	Convulsions
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat, Chest Pains (circle)
☐	☐	Loss of Appetite, Anorexia (circle)
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Depression
☐	☐	Painful or Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Heartburn/Indigestion
☐	☐	Difficulty in Swallowing
☐	☐	Dermatitis/Eczema/Rash

Yes	No	
☐	☐	Do you have permanent Disability Rating? Where: _____
☐	☐	Date rating received_____/____/_____
☐	☐	Rating Percentage_____%

This box for women only:

Past	Present	Condition
☐	☐	Menstrual Flow: Irregular, Profuse (circle)
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Pregnancy, # Births:_____
☐	☐	Birth Control Pills, Type:_____
☐	☐	Breast implants/Augmentation

Health Questionnaire continued ……..

The following lists a variety of conditions that patients may experience. Please read through the following list and check the box next to each condition, if it applies to you.

- □ Neck pain with difficulty swallowing.
- □ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck.
- □ Leg pain that worsens with exercise but is relieved by resting.
- □ Loss of feeling in inner thighs.
- □ Back pain with urinary problems.
- □ Severe pain that interrupts sleep.
- □ Constant pain that does not improve by changing position or lying down.
- □ Recent unexplained weight loss.
- □ Recent progressive muscle weakness or shaking.
- □ Recent or current fever over 102°F.
- □ Loss of bowel or bladder control.
- □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions.
- □ Recent major accident such as a fall from height, whiplash or blow to the head.
- □ Memory loss after injury.
- □ History of compression fracture.
- □ Immune suppression such as from Chemotherapy, organ transplant, etc.
- □ 3 or more months use of steroid medications or intravenous drugs. (past or recent)

- In general would you say your **overall health right** now is: Excellent Very Good Good Fair Poor
- **How tall are you?**_____'_____" **What is your present weight?**_____**lbs.**
- Do you **sleep** well? □ Yes □ No What are your normal sleeping hours?_____to _____
- Do you wear **orthotics** (shoe inserts)? □ Yes □ No If Yes, What kind and for what reason? _____
- Are you **currently under the care** of a medical doctor or other type of health care provider for any condition?

  □ No □ Yes → For what condition? _____

  Name of doctor/provider:_____Phone number: _____
- Who have you seen for symptoms? □ No one □ Medical Doctor □ Other □ Chiropractor □ Physical Therapist
  - What treatment did your receive and when? _____
  - What tests have you had for your symptoms and when were they performed? □ X-rays, date: _____ □ MRI, date: _____ □ CT Scan, date: _____ □ Other, date: _____
- Have you ever had an **overnight stay in a hospital or a surgical procedure** of any kind?

  □ No □ Yes → If yes, please describe the event below:

  Event_____Year _____

  Event_____Year _____
- Are you currently taking **any prescription medication**?

  □ No □ Yes → 1. _____ 2._____3. _____

  4. _____ 5._____6. _____
- Please check any of the following that apply to you:

Past	Present	
□	□	Alcohol – Drinks per week: _____
□	□	Drug or Alcohol dependence
□	□	Tobacco – Packs per Day_____Years _____
□	□	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day: _____

Family history

If a family member has had any of the following please mark the appropriate box:

□ Arthritis	□ Cancer	□ Chronic headaches	□ Chronic back pain	□ Diabetes
□ Epilepsy	□ Heart disease	□ High blood pressure	□ Kidney disease	□ Lupus
□ Lung problems	□ Mental illness	□ Osteoporosis	□ Rheumatoid arthritis	□ Other: _____

Complaints/Symptoms Form

Please carefully list and explain your reason(s) for this visit in the order of importance below.

#1 _____ Date you first noticed: _____

#2 _____ Date you first noticed: _____

#3 _____ Date you first noticed: _____

Problem #1:

Location of pain: □ Right side □ Left side □ Both sides
During what time of the day does this feel worse? _____
Does the pain radiate to different areas? □ Yes □ No
If yes, where to: _____

How severe is the pain? (Please make an "X" on the line below)

no pain ←——————————→ severe pain

During a normal day (awake hours) how frequently do you experience the pain/problem?

□ 0 –25 % of the time □ 25 – 50 % of the time

□ 50 – 75 % of the time □ 75 – 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain how this problem happened:

□ Developed over time
□ Illness
□ Injury
□ Auto Accident
□ Other
□ I don't know

Explain:

_____
_____
_____

Problem #2:

Location of pain: □ Right side □ Left side □ Both sides
During what time of the day does this feel worse? _____
Does the pain radiate to different areas? □ Yes □ No
If yes, where to: _____

How severe is the pain? (please make an "X" on the line below)

no pain ←——————————→ severe pain

During a normal day (awake hours) how frequently do you experience the pain/problem?

□ 0 –25 % of the time □ 25 – 50 % of the time

□ 50 – 75 % of the time □ 75 – 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain how this problem happened:

□ Developed over time
□ Illness
□ Injury
□ Auto Accident
□ Other
□ I don't know

Explain:

_____
_____

Problem #3:

Location of pain: □ Right side □ Left side □ Both sides
During what time of the day does this feel worse? _____
Does the pain radiate to different areas? □ Yes □ No
If yes, where to: _____

How severe is the pain? (please make an "X" on the line below)

no pain ←——————————→ severe pain

During a normal day (awake hours) how frequently do you experience the pain/problem?

□ 0 –25 % of the time □ 25 – 50 % of the time

□ 50 – 75 % of the time □ 75 – 100 % of the time

What makes the pain worse? _____
What relieves the pain? _____

Please explain how this problem happened:

□ Developed over time
□ Illness
□ Injury
□ Auto Accident
□ Other
□ I don't know

Explain:

_____
_____
_____

Pain/Symptom Drawing

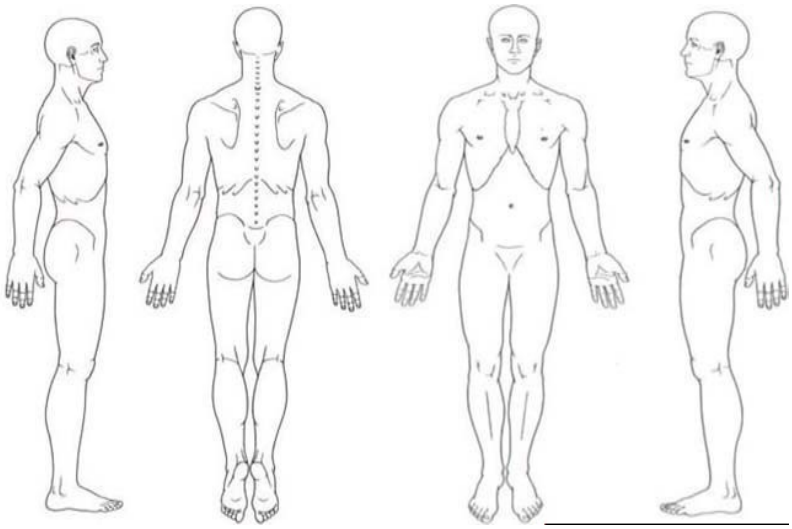
On the picture below, please describe your problems by drawing, circling, and making arrows to the appropriate regions. (e.g. Numbness, pain, weakness, tingling)

Write and draw as much as you need to explain the problem(s).

+++	Sharp and stabbing pain
//////	Pins and needles sensation
VVVV	Dull or aching pain
oooo	Numbness

How are your symptoms changing? □ Getting better □ Not changing □ Getting worse

Please write any additional comments below:



How did you hear about Lazarus Chiropractic, Inc? _____

What do you expect to achieve from your visit and/or future visits with Dr. Ryan Lazarus, D.C./Dr. Matt Murphy, D.C.

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify Lazarus Chiropractic, Inc. immediately whenever I have a change in my health condition.
- I consent to the release of my confidential medical and patient information in the possession of Lazarus Chiropractic, Inc, to other health care professionals to whom I am referred and to the insurance company or other entity responsible for payment for all or portion of my care.
- I authorize Dr. Lazarus, D.C./Dr. Murphy, D.C. and their staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to Lazarus Chiropractic, Inc. for services rendered.
- Our policy requires payment for services rendered at the time of visit unless other arrangements have been made with the office manager. I agree to pay 1% interest per month on any overdue balances. I understand that I am ultimately liable for all charges for services rendered.
- Please note that we reserve the right to charge for appointments missed or cancelled without 24 hours advance notice.

Signed (patient or authorized person): _____ **Date:** _____