Body•Mind
Balanced Wellbeing
RECONNECT NATURALLY TO YOUR HEALTH.

CONFIDENTAL PATIENT DATA

If you need any assistance completing this form, please ask the receptionist

PATIENT INFORMATION

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____ Email_____

Age_____ D.O.B._____ Last 4 digits of S.S. # XXX-XX-_____

Marital Status □Married □Single □Divorced □Separated □_____

Name of Spouse or Nearest Relative_____ Phone_____

Your Occupation_____ Employer_____

Whom may we thank for referring you?_____

(If applicable)

Name of Insurance _____Insureds Employer_____

Are you covered by more than one insurance company? □ No □Yes _____

MEDICAL/FAMILY HISTORY

S=Self M=Mother F=Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F	S	M	F	S	M	F
O	O	O AIDS	O	O	O Epilepsy	O	O	O Neck Pain
O	O	O Anemia	O	O	O German Measles	O	O	O Nervousness
O	O	O Arthritis	O	O	O Headaches	O	O	O Numbness
O	O	O Asthma	O	O	O Heart Trouble	O	O	O Polio
O	O	O Back Pain	O	O	O Hepatitis	O	O	O Poor Circulation
O	O	O Bladder Trouble	O	O	O High Blood Pressure	O	O	O Reproductive Disorders
O	O	O Bone Fracture	O	O	O HIV/ARC	O	O	O Rheumatic Fever
O	O	O Cancer	O	O	O Indigestion	O	O	O Rheumatism
O	O	O Chest Pain	O	O	O Kidney Disorder	O	O	O Scarlet Fever
O	O	O Concussion	O	O	O Bowl Control Loss	O	O	O Serious Injury
O	O	O Convulsions	O	O	O Menstrual Cramps	O	O	O Sinus Trouble
O	O	O Diabetes	O	O	O Multiple Sclerosis	O	O	O Tuberculosis
O	O	O Dislocated Joints	O	O	O Muscular Dystrophy	O	O	O Venereal Disease

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

Describe Condition_____Date of last physical exam_____

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Surgical History:

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____

Have you ever had a metal implant? □ Yes □ No
Have you ever been gun shot? □ Yes □ No

Accident History:

□ Job □ Auto □ Other _____ Date_____
□ Job □ Auto □ Other _____ Date_____
□ Job □ Auto □ Other _____ Date_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Please rate your symptoms (1-10, with 1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Symptoms are worse in: □Morning □Afternoon □Night
Do you know when/how they occurred?_____

_____

Symptoms developed from: □Job related injury □Auto Accident □Other □Accident □Illness
□Unknown cause □Gradual Onset □Sudden Onset Date Occurred_____
Symptoms have persisted for _____Hours _____ Days _____ Weeks _____ Months _____ Years
Symptoms/Complaints: □Come & Go □Are Constant
Have you ever had this before? □No □Yes If so, when?_____
If you were to guess, what is the cause of your symptoms/complaints?_____
Name and locations are Doctors previously seen for conditions_____

_____

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Are you allergic to any medications? □No □Yes if so, what kind? _____

Are you taking any medications? _____

_____

Are you pregnant? □No □Yes Date of last menstrual period? _____

Please check the following activities that aggravate your condition:

□Bending □Reaching □Straining at stool □Coughing □Sitting □Turning head □Lifting
□Sneezing □Walking □Laying down □Standing □Exercise

Please check the following activities that relieve your condition:

□Bending □Sitting □Lifting □Standing □Laying down □Turning head □Reaching □Walking

Please circle any additional symptoms you may be experiencing:

blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss/confusion
constipation depression/weeping spells diarrhea dizziness flushed-face fainting fatigue fever
head seems to heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste
low resistance to colds muscle jerking numbness in fingers numbness in toes pins/needles in arms
pins/needles in legs ringing in ears shortness of breath stomachaches

Signature _____ Date_____

*Minor: Parent/Guardian Signature