

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
<input type="radio"/>	<input type="radio"/>	Neck Pain
<input type="radio"/>	<input type="radio"/>	Shoulder Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Pain in Upper Arm or Elbow (R__ L__)
<input type="radio"/>	<input type="radio"/>	Hand Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Wrist Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Upper Back Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Lower Back Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Pain in Upper Leg or Hip (R__ L__)
<input type="radio"/>	<input type="radio"/>	Pain in Lower Leg or Knee (R__ L__)
<input type="radio"/>	<input type="radio"/>	Pain in Ankle or Foot (R__ L__)
<input type="radio"/>	<input type="radio"/>	Jaw Pain (R__ L__)
<input type="radio"/>	<input type="radio"/>	Headache
<input type="radio"/>	<input type="radio"/>	Swelling, Stiffness of Joint(s)

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

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

Yes	No	
<input type="radio"/>	<input type="radio"/>	Do you have permanent Disability Rating?
		Where: _____
<input type="radio"/>	<input type="radio"/>	Date rating received ___/___/___
<input type="radio"/>	<input type="radio"/>	Rating Percentage _____%

This box for women only:

Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Menstrual Flow: Irregular, Profuse (circle)
<input type="radio"/>	<input type="radio"/>	Breast <input type="radio"/> Soreness <input type="radio"/> Lumps
<input type="radio"/>	<input type="radio"/>	Endometriosis
<input type="radio"/>	<input type="radio"/>	PMS
<input type="radio"/>	<input type="radio"/>	Pregnancy, # Births: _____
<input type="radio"/>	<input type="radio"/>	Birth Control Pills, Type: _____
<input type="radio"/>	<input type="radio"/>	Breast implants/Augmentation

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

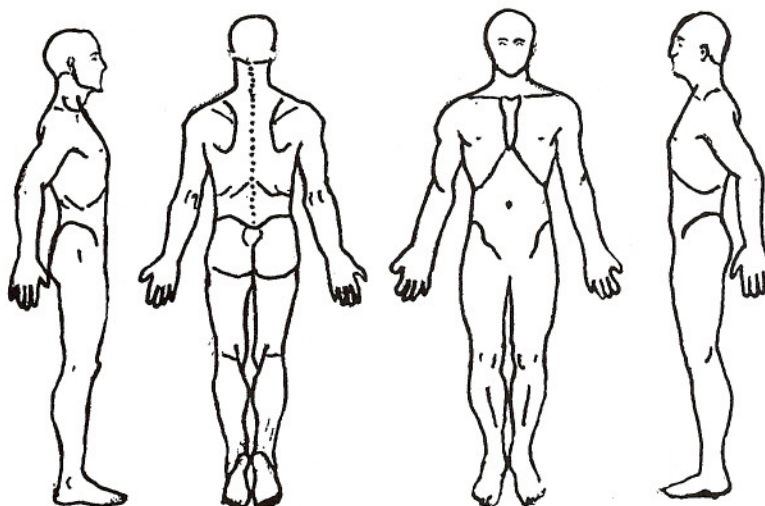
How are your symptoms changing?

Getting better

Not changing

Getting worse

Please write any additional comments below:



How did you hear about South Tulsa Performance Health?

What do you expect to receive from your visit and /or future visits with us?

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify the doctor immediately whenever I have a change in my health condition.
- I consent to the release of my confidential and patient information in the possession of South Tulsa Performance Health to other health care professionals whom I am referred and to the insurance company or other entity responsible for payment for all or portion of my care.
- I authorize South Tulsa Performance Health and their staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to South Tulsa Performance Health for services rendered.
- Our policy requires payment for services rendered at time of visit unless other arrangements have been made with the office manager. I agree to pay 1.5% interest per month on any overdue balances. I understand that I ultimately liable for all charges for services rendered.
- All HIPPA guidelines and requirements are followed in this office if you would like a copy of the HIPPA requirements please ask for them at the front desk.

Signed (patient or authorized person) _____ Date: _____