Confidential Patient Data

Today's Date: _____

Name:_____Birthday: _____ ☐Male ☐Female

Street:_____ City, State:_____ Zip:_____

Phone: (H)_____Work: _____ext:_____ Cell:_____

E-mail: _____ Preference to contact: ❑Home ❑Work ❑Cell ❑E-mail ❑Any

Occupation:_____ Employer: _____

Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Other _____

Name of Spouse or Nearest Relative:_____ Phone:_____

Referred by: _____☐Friend/Family ☐Physician ☐Patient
❑Insurance plan ☐Yellow Pages ☐ Internet ☐Office Location ☐Other_____

Payment for Services by: ☐Cash ☐Check ☐Credit Card ☐Health Insurance ☐Auto Insurance ☐W/Comp

If using insurance, policy holder's: Name_____Birthday::_____

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	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	numbness
☐	☐	☐	allergies	☐	☐	☐	epilepsy	☐	☐	☐	polio
☐	☐	☐	anemia	☐	☐	☐	fibromyalgia	☐	☐	☐	osteoporosis
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	poor circulation
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	reproductive disorders
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	rheumatic fever
☐	☐	☐	bladder trouble	☐	☐	☐	hepititis	☐	☐	☐	rheumatism
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	scarlet fever
☐	☐	☐	cancer	☐	☐	☐	high cholesterol	☐	☐	☐	scoliosis
☐	☐	☐	chest pain	☐	☐	☐	HIV/ARC	☐	☐	☐	serious injury
☐	☐	☐	concussion	☐	☐	☐	kidney disorder	☐	☐	☐	sinus trouble
☐	☐	☐	constipation	☐	☐	☐	bowel control loss	☐	☐	☐	stroke
☐	☐	☐	convulsions	☐	☐	☐	ling disease	☐	☐	☐	thyroid disorder
☐	☐	☐	deceased	☐	☐	☐	menstrual cramps	☐	☐	☐	ulcers
☐	☐	☐	depression	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	diarrhea	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease
☐	☐	☐	diabetes	☐	☐	☐	neck pain				
☐	☐	☐	digestive disorders	☐	☐	☐	nervousness	☐	☐	☐	_____

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

If Yes, describe condition:_____ Date of Last Physical Exam_____

SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ☐Yes ☐No

ACCIDENT HISTORY: ☐Job ☐Auto ☐Other _____ Date:_____
☐Job ☐Auto ☐Other _____ Date:_____

(Please also complete reverse page)

MAJOR COMPLAINT / SYMPTOM: Rate your major symptom, 1 TO 10. 1=MILD 10=EXCRUCIATING

1._____

	Presently:	1	2	3	4	5	6	7	8	9	10
Circle Level of	At best:	1	2	3	4	5	6	7	8	9	10
Severity:	At worst:	1	2	3	4	5	6	7	8	9	10
	On average:	1	2	3	4	5	6	7	8	9	10

When symptom started:_____ Worse in: □A.M.. □ AFTERNOON □NIGHT □VARIES □SAME/CONSTANT

Symptoms developed from: □Work Injury □Auto Acci □Sports □Unknown □Gradual Onset □Other:_____

Describe Incident_____
Symptom has persisted for # _____HOUR(S) _____DAY(S) _____WEEK(S) _____MONTH(S) _____YEAR(S)

What single activity of daily living is most affected by this problem?: _____

Have you had this complaint before? □NO □YES WHEN?_____

What do you think is causing this complaint? _____

OTHER COMPLAINTS: Again, circle the severity of your symptoms, 1 to 10 (1=MILD, 10=EXCRUCIATING)

2._____ Severity: 1 2 3 4 5 6 7 8 9 10

3._____ Severity: 1 2 3 4 5 6 7 8 9 10

4._____ Severity: 1 2 3 4 5 6 7 8 9 10

5._____ Severity: 1 2 3 4 5 6 7 8 9 10

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

Are you allergic to any medications? □NO □YES What kind?_____
Are you taking any medications? □NO □YES If yes, list below. If list is extensive, please ask for additonal paper.

List:_____ Taking For: _____
_____ For: _____
_____ For: _____
_____For: _____

Are you pregnant? □NO □YES

What activities aggravate your condition? □BENDING □REACHING □STRAINING AT STOOL
□COUGHING □SITTING □TURNING HEAD □LIFTING □SNEEZING
□WALKING □LYING DOWN □STANDING □OTHER(S)_____

What relieves your condition? □BENDING □SITTING □LIFTING □STANDING □LYING DOWN
□TURNING HEAD □REACHING □WALKING □NOTHING
□OTHER(S): _____

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
□blurred vision □buzzing in ears □cold feet □cold hands □cold sweats □concentration loss □constipation
□depression □diarrhea □dizziness □face flushed □fainting □fatigue □fever
□head seems 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 □stiff neck □stomach upset

Patient's Signature:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

From the Offices of

Richard Therkelsen, D.C.
400 Belchase Dr., Suite 404
Matawan, NJ 07747

I understand that I have the right to refuse to sign this acknowledgement.

I, _____, have received a copy of the

Notice of Privacy Practices for the above referenced practice.

_____

(PLEASE PRINT NAME)

_____ _____

(SIGNATURE) (DATE)