

Confidential Patient Information - 4 pages

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

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

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

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

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

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

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

This box for women only:

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

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

• 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

o What treatment did your receive and when? _____

o 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:

- | | | | | |
|--|---|--|---|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> 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:

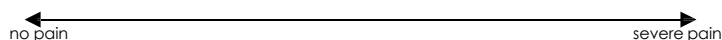
Location of pain: Right side Left side Both sides

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:

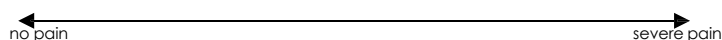
Location of pain: Right side Left side Both sides

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:

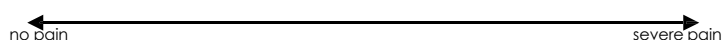
Location of pain: Right side Left side Both sides

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

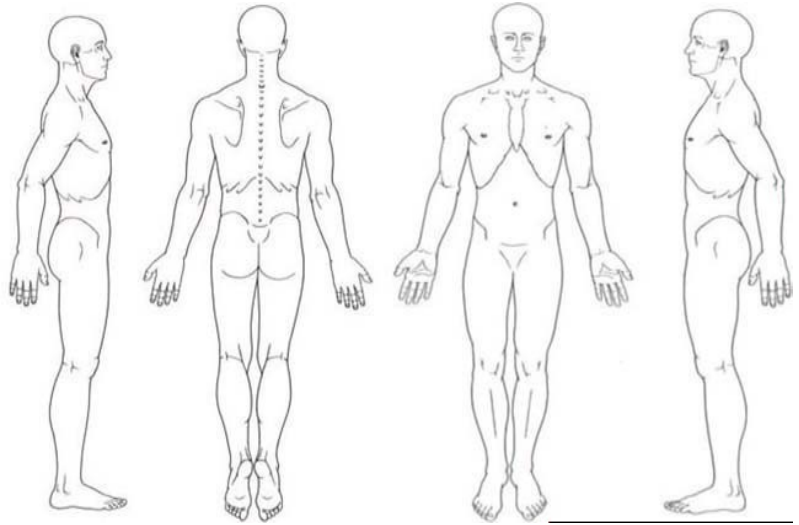
On the picture below, please describe your problems by drawing, circling, and making arrows to the appropriate regions. (e.g. Numbness, pain, weakness, tingling)

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:** _____