CONFIDENTIAL PATIENT INFORMATION Date____________

Name______________________ Home Phone ( )______________
Address______________________ City__________ State______ Zip Code________
Age__________ Birth Date______________ Height__________ Weight________ Marital: M S W D
Occupation______________ Employer______________ Phone ( )______________
Address______________ City__________ State______ Zip________ SSN#__________
D.L.#______________
Name of Spouse______________ No. of Children__________ Phone ( )__________
Employer______________ Address______________ Phone ( )__________
Nearest Relatives Name__________ Address______________ Phone ( )__________
Referred By:______________________________
Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
Describe:______________________________
Date of Last Physical Examination:______________________________
What Operations have you had?______________________ When?__________
Serious Illness?______________________ When?__________
If Female, Are you pregnant? Yes ☐ No ☐ Maybe ☐

Have you ever suffered from:

1. Dizziness__________
2. Backaches__________
3. Heart Trouble__________
4. Diabetes__________
5. Tuberculosis__________
6. Arthritis__________
7. Headaches__________
8. Numbness__________
9. Asthma__________
11. Digestive Disorder__________
12. Nervousness__________
13. Sinus__________
14. Anemia__________
15. Cancer__________
16. Rheumatic Fever__________

Purpose of this appointment:______________________________
Other Doctors seen for this condition:______________________________
What medications of drugs are you taking?______________________________
Name of person responsible for payment?______________________________

PAYMENT IS EXPECTED AT TIME OF VISIT!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. David Noel, DC will furnish me any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. David Noel, DC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable, otherwise interest charges may accrue.

Patient's Signature______________________________

Signature of guardian or spouse authorizing care:______________________________

COMPLETE THE REVERSE SIDE IF THIS IS AN ACCIDENTAL INJURY

IF YOUR VISIT IS DUE TO AN ACCIDENTAL INJURY COMPLETE THE FOLLOWING QUESTIONS

Date of Accident:__________ Hour __________ AM______ PM______ Location:__________________
Type of Accident? ☐ Auto ☐ On the job ☐ Other______________________________
If **auto**, answer the following:
Were you the ☐ Driver ☐ Passenger ☐ Pedestrian
Were you struck from ☐ Behind ☐ Right Side ☐ left Side ☐ Front ☐ Auto was Parked
Did you strike the other car? ☐ Yes ☐ No
Did the other car strike yours? ☐ Yes ☐ No
Were citations issued to you? ☐ Yes ☐ No
To the driver of the other car? ☐ Yes ☐ No
Did you require Post-Accident Hospitalization? ☐ Yes ☐ No

If **Industrial**, answer the following:
Did you report the injury to your employer? ☐ Yes ☐ No

Describe how the accident happened:
____
____
____
____

Auto or industrial check the following symptoms you have noticed since accident:

☐ Headaches	☐ Face flushed	☐ Head seems heavy	☐ Cold sweats	☐ Ears ring
☐ Neck pain	☐ Loss of smell	☐ Pins & needles in arms	☐ Numbness in toes	☐ Fainting
☐ Neck stiff	☐ Feet cold	☐ Pins & Needles in legs	☐ Shortness of breath	☐ Diarrhea
☐ Sleeping problems	☐ Constipation	☐ Numbness in fingers	☐ Fatigue	☐ Stomach upset
☐ Back pain	☐ Irritability	☐ Loss of balance	☐ Depression	☐ Fever
☐ Nervousness	☐ Chest pain	☐ Loss of taste	☐ Lights bother eyes	☐ __________
☐ Tension	☐ Dizziness	☐ Hands cold	☐ Loss of memory	☐ __________

Other symptoms:____

Have you lost any days of work?__________ How Many?______________________________
Insurance companies involved:
Your company ______________________________ Claim No:____________________
Address ______________________________________ Phone ( )____________________
Company of person responsible ____
Do you have an attorney advising you in this case? ☐ Yes ☐ No
Name____________________ Address ______________________________ Phone ( )__________

PAIN ASSESSMENT

Patient Name ______________________________ Date ______________

Chief Complaint 1. ______________________ 2. ______________________

Is your present problem due to an injury

☐ On the job? ☐ Auto Accident? ☐ Other ______________________

Did your pain begin ☐ Gradually? ☐ Suddenly

Do you have pain ☐ All the time? ☐ Sometimes?

Is your pain worse when you

☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other ______________________

Which of the following areas do you have the most pain, discomfort or restriction of motion?

☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back ☐ Mid Back ☐ Low Back

☐ Pelvis ☐ hips ☐ Legs ☐ Knees ☐ Feet ☐ Other ______________________

IN AN 8 HOUR DAY RATE THE PERCENTAGE OF YOUR PAIN WHEN YOU :

Sit ______________ %ofthetime

Stand ______________ % of the time

Walk ______________ % of the time

OCCASIONALLY= 33%

FREQUENTLY= 34-66%

CONTINUOUSLY= 67-100%

WHAT PERCENTAGE OF YOUR TIME ARE YOU:

☐ Housebound? ______________ %

☐ Chair bound? ______________ %

☐ Bedfast? ______________ %

RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE.

1 = LEAST PAIN

10 = EXTREME PAIN

EXTREME

☐ 10
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1
☐ 0

NO PAIN

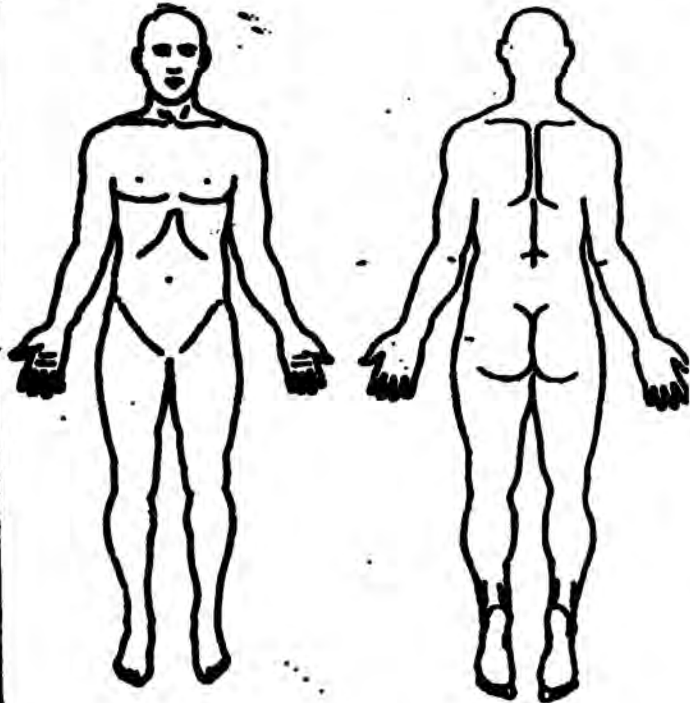
MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES

+++ BURNING

||| CONSTANT

000 STABBING

— SHARP



Does your pain interfere with your:

☐ Work? ☐ Sleep? ☐ Daily Routine?

Do you feel your present condition is ☐ Temporary? ☐ Permanent? ☐ Don't Know

List any additional comments you wish to make regarding your condition ______________________

____

____

Patient Signature ______________________________