

Health Pointe Jacksonville, LLC

Confidential Patient Information

Name _____ Date _____ Age _____

Address _____

Gender _____ Birth Date _____ Social Security # _____

Email _____ Would you like to receive our newsletter? Y _____ N _____

Occupation _____ Phone _____

Referred by _____ Marital Status _____

In case of emergency _____ Phone _____

Primary Care Physician _____ Phone _____

What brought you to the clinic today? _____

Review of Systems: Please write in a number; 1.Presently Have 2.Previously Had 3.Related to Accident

General

- Allergies
- Bruise easily
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Sleep loss
- Weight-loss/gain
- Nervousness
- Neuralgia
- Numbness
- Sweats
- Tremors
- Anxiety/Depression

Eyes, Ears, Nose, Throat

- Asthma
- Colds
- Sore throat
- Deafness
- Dental decay
- Earache/noises
- Ear discharge
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Nose bleeds
- Failing vision
- Hoarseness
- Gum trouble
- Nasal obstruction

Musculoskeletal

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain/stiffness
- Shoulder blade pain

Pain or numbness in:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Ankles
- Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature

Genito-urinary

- Bedwetting
- Blood in urine
- Frequent urination
- Inability to control bladder
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Hot flashes
- Painful menstruation
- Irregular cycle

Cardiovascular

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Swelling of ankles

Respiratory

- Wheezing
- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm

Gastrointestinal

- Poor appetite
- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distention of abdomen
- Excessive hunger
- Heartburn/reflux
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver problems
- Nausea
- Vomiting

Patient Name _____

Date _____

Current Medication: Please list the names and dosages. (All vitamins, supplements, and over-the-counter)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

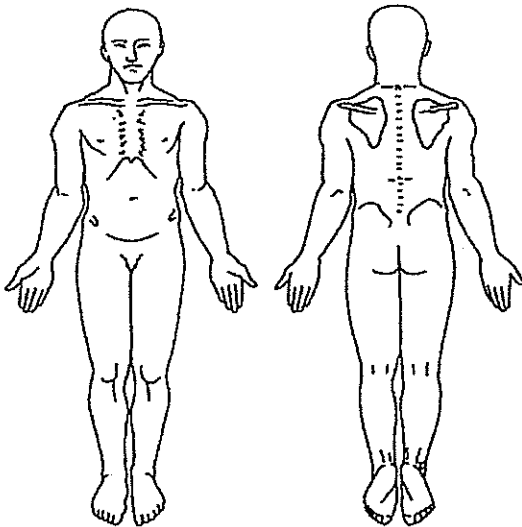
Allergies: medications, food, environmental etc.

Family History: Please check any of the following that you aware of.

Relatives	Arthritis	Cancer	Stroke/Heart Disease	Kidney Disease	Diabetes	Thyroid Disease	Neurological Disease
Father							
Mother							
Brother/Sister							
Grandparents							

Mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.

Numbness +++++
 Pins & Needles 00000
 Burning xxxxx
 Aching *****
 Sharp / Stabbing /////



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

Doctor Only:

Patient Name _____

Date _____

List physical activities you participate in regularly _____

What movements or activities are limited? _____

Describe the events of the injury or accident: _____

List previous major injuries/surgeries: _____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

What seems to help the most? _____

What seems to aggravate the condition the most? _____

What is your main activity at work? On phone _____ Sitting _____ Computer work _____

Driving car _____ Walking _____ Other _____

What do you do to relieve stress? _____

What do you want to get out of your session(s)? _____

I affirm that I have stated all of my known medical conditions, and answered all questions truthfully. I agree to keep the practitioner updated as to any changes in my medical information and understand that there shall be no liability on the practitioner's part should I not do so. I understand that any information discussed during my session is for educational purposes and is not in any way to take the place of medical advice from my doctor.

Name _____

Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer any therapies to my child or dependent as they deem necessary.

Signature of Parent or guardian _____

Date _____