

# Confidential Patient Information

**Your First Name:**

MI:

Last Name:

- Male  
 Female

Date of Birth:

Age:

Social Security Number:

Number of Children:

**Your Marital Status:** Single Married Divorced Widowed

**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/Cell Phone Number:

E-mail Address:

**Employer Name:**

Your Job Title/Occupation:

Years Employed:

**Work Address:**

City:

State:

Zip:

**Insurance Information:**

Insurance Company

ID#

Phone#

Claims Address:

City:

State:

Zip:

**\*Please present your Insurance Card at your office visit.**



## Health Questionnaire continued...

- 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?  
Yes No If yes, for what condition? \_\_\_\_\_  
Name of Doctor/Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_
- Who have you seen for symptoms? No one Medical Doctor Other  
Chiropractor Physical Therapist
- What treatment did you receive and when? \_\_\_\_\_
- What test 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?  
Yes No If yes, please describe the event below:  
Event: \_\_\_\_\_ Year: \_\_\_\_\_  
Event: \_\_\_\_\_ Year: \_\_\_\_\_
- Are you currently taking **any prescription medication**?  
Yes No 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_
- Please check any of the following that apply to you:  

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol - Drinks per week: _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol dependence
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco - Packs per Day _____ years _____
<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_

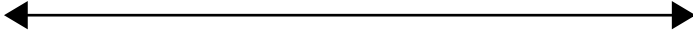
#2 \_\_\_\_\_ Date you first noticed: \_\_\_\_\_

#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)



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

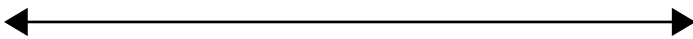
Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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)



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

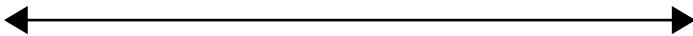
Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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)



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

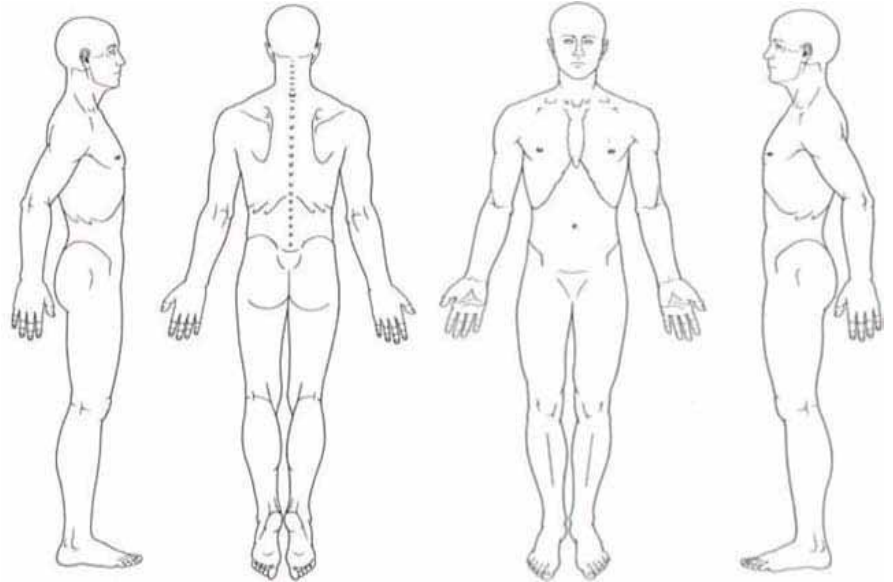
How are your symptoms changing?

Getting better

Not changing

Getting worse

Please write any additional comments below:



How did you hear about Dr. Matthew Hemsley? \_\_\_\_\_

What do you expect to achieve from your visit and/or future visits with Dr. Hemsley?  
\_\_\_\_\_

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify Dr. Hemsley 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 Dr. Hemsley to other health care professionals to whom I am referred and to the insurance company or other entity responsible for payment for all or a portion of my care.

- I authorize Dr. Hemsley and his staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to Dr. Hemsley 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:** \_\_\_\_\_