PERSONAL DATA SHEET

Patient's Name ____ Date____________

Address ____City_____________ State____Zip_______

Date of Birth _________ Home Phone ____________________Work Phone ______________________

Cell Phone _______________ Fax______________ email address_____________________________

Your Employer_____________________________Address_________________________________

Occupation _____________________________ Marital Status S M W D Separated

Spouse's Name _____________________________ Occupation______________________________

How were you referred to this office? ____

One person to contact in case of an emergency:

1. Name______________________ Address________________________ Phone_________________

About your complaints (if your complaint concerns weight, please complete the Weight Loss Personal Data Sheet)

What is your major complaint? ____

____

Please describe how your injury/illness occurred ____

____

Have you had same or similar conditions in the past? __________________ When? _______________

Do you have any other health problems? (Please list) _______________________________________

____

Other complaints ____

Health History

Are you under a doctor's care for any medical conditions? ____ Please describe ___________________

____

Please list surgical operations you have had and dates: ______________________________________

____

Please check drugs you now take: __Nerve pills __Pain pills __"Pep" pills __Muscle relaxers __Other

Have you ever had an injury or accident? __ Never __ Past year __ Past 5 years __ Over 5 years

Describe previous injury or accident ____

____

Family Health Information **(Please list any conditions, diseases, etc of family members)**

Name	Relationship	Past and Present Health Problems

*Please read and sign the Consent to Treat From

**Please read and sign the HIPAA Compliance Statement