

CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: ____/____/____ Date of Birth: ____/____/____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____ Age _____

SS#: _____ Male Female Email address # _____

Marital Status: Married Single Divorced Separated Other _____

Mother's Name if minor: _____ Father's Name if minor: _____

Name of Individual to contact in case of emergency: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

Employer's Number: (____) _____ Weight Frequently Required to lift is under 10 20 30 40 Lbs: _____

Referred to this office by: TV Screening Where? _____

AT&T Yellow Pages Health beat WECT WWAY Clinic Location Star News Letter

Health Journal Post Card Radio Flyer Attorney Phone Call

Friend - Name: _____ MD Name: _____ Other: _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition: _____ Date of Last Physical Exam: _____

SURGICAL HISTORY

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

ACCIDENT HISTORY

Job Auto Other: 1. _____ Date _____

Job Auto Other: 2. _____ Date _____

Job Auto Other: 3. _____ Date _____

What type of care are you looking for? Temporary Relief Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. _____

2. _____

3. _____

4. _____

THIS PROBLEM IS: RAPIDLY IMPROVING SLOWLY IMPROVING GRADUALLY WORSENING
 FLUCTUATES BUT GETTING BETTER REMAINS THE SAME RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE Morning Afternoon Evening

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: Job related injury Auto Accident Other Accident Other

ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ____ HOUR(S) ____ DAY(S) ____ WEEK(S) ____ MONTH(S) ____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

DISC HERNIATION DISC BULGE SIATICA STENOSIS

CARPAL TUNNEL DEGENERATION SPONDYLOLISTHESIS

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES WHAT KIND? _____
ARE YOU TAKING ANY MEDICATIONS? NO YES WHAT KIND? _____
ARE YOU PREGNANT? NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL COUGHING SITTING
 TURNING HEAD LIFTING SNEEZING WALKING LYING DOWN
 STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL SITTING TURNING HEAD
 LIFTING WALKING LYING DOWN STANDING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING

BLURRED VISION BUZZING IN EARS COLD FEET COLD HANDS COLD SWEATS
 CONCENTRATION LOSS/CONFUSION CONSTIPATION DEPRESSION DIARRHEA
 DIZZINESS FACE FLUSHED FAINTING FATIGUE FEVER
 HEAD HEAVY HEADACHES INSOMNIA LIGHT BOTHERS EYES
 LOSS OF BALANCE LOSS OF SMELL LOSS OF TASTE EASILY COLD STIFF NECK
 MUSCLE JERKING NUMBNESS IN FINGERS NUMBNESS IN TOES
 RINGING IN EARS SHORTNESS OF BREATH STOMACH UPSET
 PINS AND NEEDLES IN ARMS PINS AND NEEDLES IN LEGS

PLEASE EXPLAIN WHAT YOU HAVE DONE TO TRY TO FIX THE PAIN.

HAVE ALL OF THESE TREATMENTS FAILED TO FIX YOUR PROBLEM? YES NO

HOW HAS THIS PROBLEM AFFECTED YOUR DAILY ACTIVITIES?

PLEASE CIRCLE YOUR LEVEL OF PAIN ON THE SCALE BELOW.

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Dr. Holland to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature _____ Date _____