Confidential Patient Data

Name: _____Date of Birth:_____ Age:_____

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

Home Phone:_____ Cell Phone: _____Work Phone: _____

Marital Status: □ Married □Single □Divorced □Separated □Other _____

Name of Spouse or Nearest Relative: _____ Phone:_____

Occupation_____ Employer:_____Your E-Mail_____

Name of Insurance Co:_____(We will photocopy your ID card.)

MEDICALHISTORY (Please indicate which conditions apply to **you**.)

□ Depression / Anxiety
□ Diabetes
□ High Blood Pressure
□ Stroke (date) _____
□ Corticosteroid Use (cortisone, prednisone, etc)
□ Taking Birth Control Pills
□ Dizziness or Fainting
□ Numbness in Groin or Buttocks
□ Recent High Fever
□ Epilepsy/Seizures
□ Cancer/Tumor(explain)_____
□ Currently Pregnant # of weeks _____
□ Abnormal Weight □ Gain □Loss Why?_____
□ Noticeable Morning Pain or Stiffness
□ Pain is NOT relieved by Changing Position or Resting
□ Pain at Night
□ Chronic Pain more than 3 months_____
□ Other Health Problems _____

FAMILY HISTORY:

Mother □ Cancer □ Heart Problems □Stroke □High Blood Pressure □Diabetes □Rheumatoid Arthritis
Father □ Cancer □ Heart Problems □Stroke □High Blood Pressure □Diabetes □Rheumatoid Arthritis

Have you been treated by a physician for any condition in the last year? □ Yes □ No Date of Last Visit_____

Describe Condition_____ Physicians Name_____
Have you had spinal X-rays, MRI,CT for this condition? If yes date taken?_____

Your Primary Care Physician_____
SURGICAL HISTORY:
1._____Date:_____
2._____ Date:_____
Have you ever had a metal implant? □Yes □No

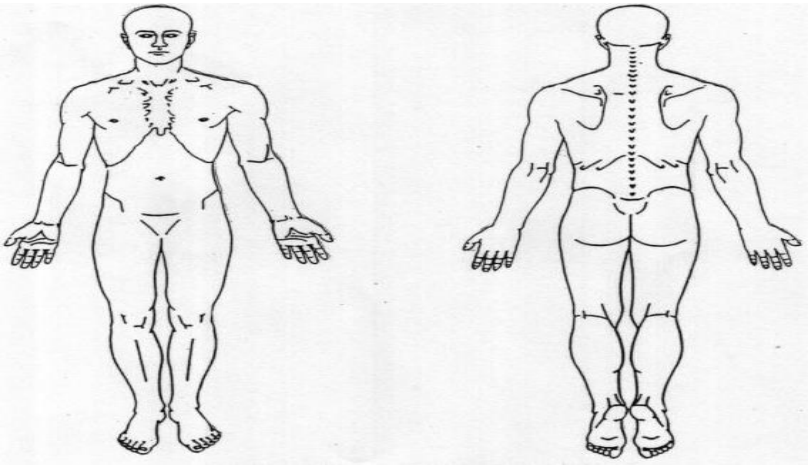
ACCIDENT HISTORY:
□ Job □ Auto □Other_____Date:_____
□ Job □ Auto □Other_____Date:_____

Social History

Tobacco usage	Never □	Former □	Occasional □	Everyday □
Alcohol usage	None □	Light □	Moderate □	Heavy □
Drug usage	None □	Light □	Moderate □	Heavy □
Exercise	Never □	Seldom □	Occasional □	Frequent □

Y	N	**Review of Body Systems**	Y	N	
□		Respiratory- hearing, sinus, allergy, throat_____	□		Male-Prostate, other_____
□		Heart//Lungs- chest pain or heart palpitations,asthma _____	□		Neurological- Seizures, falling, arm/leg weakness_____
□		Vascular-edema, coldness, varicose veins,swelling_____	□		Endocrine ankle swelling, fatigue , sudden weight change____
□		Urinary-Frequency, urgency, infection, stones _____	□		Blood//Lymphatic- Swollen lymph nodes,anemia. clots__
□		Female- PMS, menopausal, weight change _____	□		Allergy – Food, airborne, hay fever_____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
□ blurred vision □ buzzing-ears □ cold hands or feet □ weak arms or legs □ numb hands or feet □ fatigue □ loss of balance



Mark with an X on the picture where you have pain or other symptoms

□ **Headache** □ **Neck Pain** □ **Mid/Upper Back Pain** □ **Low Back Pain** □ **Other_____**

Circle the number that best describes your pain, 1 to 10 (with 1 being least severe)

---

0 1 2 3 4 5 6 7 8 9 10

SYMPTOMS ARE WORSE IN □ Morning □ Afternoon □ Evening □ Sleeping/Nighttime

Describe the pain **:** □ache □dull □stiff □tight □sharp □burning □throbbing □shooting □diffuse □deep □numb □tingle

Date problem began?_____ How problem began?_____

SYMPTOMS RELATED TO: □ Reported Work Injury □ Auto Injury □ No Injury □ Other_____
FREQUENCY of SYMPTOMS: □ 0 to 25% □25 to 50% □ 50 to 75% □ 75 to 100% □ Constant □ Constant -varies

Interference with daily activities, 1 to 10 (with 1 being least severe)

---

0 1 2 3 4 5 6 7 8 9 10

HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS CONDITION? □ **NO** □ **YES**
□ Medication for Pain □ Muscle relaxer □Anti-inflammatory □ Therapy:_____ □ Steroid injection □ Chiropractor

Are you allergic to any medications**?** □ NO □ YES What kind?_____
CURRENT MEDICATIONS □ NO □ YES List by: Name- Strength- Daily Dosage

1_____ **2**_____ **3**_____ **4**_____

DAILY ACTIVITIES THIS CONDITION INTERFERES WITH**:**

□ SLEEPING/LYING DOWN □ SITTING □ WALKING □ STANDING □ DRIVE CAR □ EXERCISE
□ HOUSEWORK □ DRESSING/BATHING □ LIFTING HURTS NECK □ LIFTING HURTS LOW BACK

Any others? □_____ □ _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *RELIEVE* YOUR CONDITION:
□ BENDING □ SITTING □ STRETCHING □ STANDING □ LYING DOWN □ WALKING □ _____

Your Signature:_____ **Date:**_____

Ronald Czop DC 2532 Eastern Blvd York PA 17402 reviewed_____