Confidential Patient Data

Today's Date: ____________________

Name:____Birthday: __________________ ☐Male ☐Female

Street:_________________________________ City, State:_____________________________ Zip:____________

Phone: (H)______________________Work: ____________________ext:_______ Cell:______________________

E-mail: ____________________________________ Preference to contact: ❑Home ❑Work ❑Cell ❑E-mail ❑Any

Occupation:________________________________ Employer: ____

Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Other _________________________

Name of Spouse or Nearest Relative:________________________________ Phone:__________________________

Referred by: ____☐Friend/Family ☐Physician ☐Patient
❑Insurance plan ☐Yellow Pages ☐ Internet ☐Office Location ☐Other_____________________________

Payment for Services by: ☐Cash ☐Check ☐Credit Card ☐Health Insurance ☐Auto Insurance ☐W/Comp

If using insurance, policy holder's: Name_______________________________________Birthday::_________________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	numbness
☐	☐	☐	allergies	☐	☐	☐	epilepsy	☐	☐	☐	polio
☐	☐	☐	anemia	☐	☐	☐	fibromyalgia	☐	☐	☐	osteoporosis
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	poor circulation
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	reproductive disorders
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	rheumatic fever
☐	☐	☐	bladder trouble	☐	☐	☐	hepititis	☐	☐	☐	rheumatism
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	scarlet fever
☐	☐	☐	cancer	☐	☐	☐	high cholesterol	☐	☐	☐	scoliosis
☐	☐	☐	chest pain	☐	☐	☐	HIV/ARC	☐	☐	☐	serious injury
☐	☐	☐	concussion	☐	☐	☐	kidney disorder	☐	☐	☐	sinus trouble
☐	☐	☐	constipation	☐	☐	☐	bowel control loss	☐	☐	☐	stroke
☐	☐	☐	convulsions	☐	☐	☐	ling disease	☐	☐	☐	thyroid disorder
☐	☐	☐	deceased	☐	☐	☐	menstrual cramps	☐	☐	☐	ulcers
☐	☐	☐	depression	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	diarrhea	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease
☐	☐	☐	diabetes	☐	☐	☐	neck pain				
☐	☐	☐	digestive disorders	☐	☐	☐	nervousness	☐	☐	☐	__________________

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

If Yes, describe condition:____________________________________ Date of Last Physical Exam__________________

SURGICAL HISTORY:

1.____ Date:________________

2.____ Date:________________

3.____ Date:________________

Have you ever had a metal implant? ☐Yes ☐No

ACCIDENT HISTORY: ☐Job ☐Auto ☐Other ___________________________________ Date:________________

☐Job ☐Auto ☐Other ___________________________________ Date:________________

(Please also complete reverse page)

<u>MAJOR COMPLAINT / SYMPTOM:</u> Rate your major symptom, 1 TO 10. 1=MILD 10=EXCRUCIATING

1.____

	Presently:	1	2	3	4	5	6	7	8	9	10
Circle Level of	At best:	1	2	3	4	5	6	7	8	9	10
Severity:	At worst:	1	2	3	4	5	6	7	8	9	10
	On average:	1	2	3	4	5	6	7	8	9	10

When symptom started:_____________ Worse in: ☐A.M.. ☐ AFTERNOON ☐NIGHT ☐VARIES ☐SAME/CONSTANT

Symptoms developed from: ☐Work Injury ☐Auto Acci ☐Sports ☐Unknown ☐Gradual Onset ☐Other:______________

Describe Incident____
Symptom has persisted for # _____HOUR(S) ______DAY(S) _____WEEK(S) ______MONTH(S) ______YEAR(S)

What single activity of daily living is most affected by this problem?: ____________________________________

Have you had this complaint before? ☐NO ☐YES WHEN?____

What do you think is causing this complaint? ____

<u>OTHER COMPLAINTS</u>: Again, circle the severity of your symptoms, 1 to 10 (1=MILD, 10=EXCRUCIATING)

2.____ Severity: 1 2 3 4 5 6 7 8 9 10

3.____ Severity: 1 2 3 4 5 6 7 8 9 10

4.____ Severity: 1 2 3 4 5 6 7 8 9 10

5.____ Severity: 1 2 3 4 5 6 7 8 9 10

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
____
Are you allergic to any medications? ☐NO ☐YES What kind?____
Are you taking any medications? ☐NO ☐YES If yes, list below. If list is extensive, please ask for additonal paper.

List:____ Taking For: ___________________________
____ For: ________________________________
____ For: ________________________________
____For: ________________________________

Are you pregnant? ☐NO ☐YES

What activities aggravate your condition? ☐BENDING ☐REACHING ☐STRAINING AT STOOL
☐COUGHING ☐SITTING ☐TURNING HEAD ☐LIFTING ☐SNEEZING
☐WALKING ☐LYING DOWN ☐STANDING ☐OTHER(S)______________________________

What relieves your condition? ☐BENDING ☐SITTING ☐LIFTING ☐STANDING ☐LYING DOWN
☐TURNING HEAD ☐REACHING ☐WALKING ☐NOTHING
☐OTHER(S): ____

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

☐blurred vision ☐buzzing in ears ☐cold feet ☐cold hands ☐cold sweats ☐concentration loss ☐constipation
☐depression ☐diarrhea ☐dizziness ☐face flushed ☐fainting ☐fatigue ☐fever
☐head seems heavy ☐headaches ☐insomnia ☐light bothers eyes ☐loss of balance ☐loss of smell
☐loss of taste ☐low resistance to colds ☐muscle jerking ☐numbness in fingers ☐numbness in toes
☐pins/ needles in arms ☐pins / needles in legs ☐ringing in ears ☐shortness of breath ☐stiff neck ☐stomach upset

Patient's Signature:_________________________________ Date:______________________

Acknowledgement of Receipt of Notice of Privacy Practices

From the Offices of

John Jaeger, D.C.
3883 Route 516
Old Bridge, NJ 08857

I understand that I have the right to refuse to sign this acknowledgement.

I, ____, have received a copy of the

Notice of Privacy Practices for the above referenced practice.

____

(PLEASE PRINT NAME)

____ ______________________

(SIGNATURE) (DATE)