PATIENT INFORMATION

Name _____ Date of Birth _____ SSN _____

_____Single _____Married _____ Divorced _____Widowed

Home Address _____ Apt# _____
(address) (city & state) (zip code)

Mailing Address _____ Apt# _____
(address) (city & state) (zip code)

Email Address _____

Patient Employed By : _____

Business Address _____

Home Phone Number _____ Work _____ Cell _____

Name of Spouse _____ Spouse's Birthdate _____

Spouse's Social Security Number _____

List name, address, and phone number of two relatives not living with you:

1. _____
(name) (address) (phone #) (relation)

2. _____
(name) (address) (phone #) (relation)

How did you find out about our clinic? _____

If you found us through telephone directory or online, which one was it?

_____At&t Real Yellow Pages _____Yellow Book _____ Bayou Pages

_____Online Provider Search _____Our website _____ Sign _____ Other: _____

Briefly describe your main complaints (for example, low back pain on the left side)

_____

_____

What other health care have you received for this problem?

_____

Date of accident or when your complaints began _____

Location of accident _____

How did it occur? _____Auto Accident _____On the job _____Other

Please describe the circumstances:

_____

_____

Have you lost time from work? _____yes _____no Dates: _____

NAME: _____ DATE: _____

HEALTH QUESTIONAIRE

PLEASE CHECK ANY AND ALL SYMPTOMS YOU ARE CURRENTLY HAVING OR PREVIOUSLY HAD.

MUSCULO-SKELETAL SYSTEM
___LOW BACK PROBLEMS
___PAIN BETWEEN SHOULDER
___NECK PROBLEMS
___ARM PROBLEMS
___LEG PROBLEMS
___SWOLLEN JOINTS
___SORE MUSCLES
___WEAK MUSCLES
___WALKING PROBLEMS
___RUPTURES
___BROKEN BONES

GENITO-URINARY SYSTEM
___BLADDER TROUBLE
___EXCESSIVE URINE
___SCANTY URINATION
___PAINFUL URINATION
___DISCOLORED URINE

FEMALE
___VAGINAL BLEEDING
___VAGINAL DISCHARGE
___VAGINAL PAIN
___BREAST PAIN
___LUMPS ON BREAST

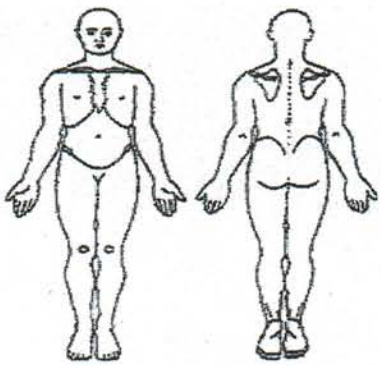
GASTRO-INTESTINAL SYSTEM
___POOR APPETITE
___EXCESSIVE HUNGER
___DIFFICULT CHEWING
___DIFFICULT SWALLOWING
___EXCESSIVE THIRST
___NAUSEA
___VOMITTING FOOD
___VOMITTING BLOOD
___ABDOMINIAL PAIN
___DIARRHEA
___CONSTIPATION
___BLACK STOOL
___BLOODY STOOL
___HEMMORHOIDS
___LIVER TROUBLE
___GALL BLADDER PROBLEMS
___WEIGHT TROUBLE

NERVOUS SYSTEM
___NUMBNESS
___DIZZINESS
___PARALYSIS
___FAINTING
___HEADACHES
___MUSCLE JERKING
___CONVULSIONS
___FORGETFULNESS
___CONFUSION
___DEPRESSION

EYE, EAR, NOSE, THROAT
___EYE STRAIN
___EYE INFLAMMATION
___VISION PROBLEMS
___EAR PAIN
___EAR NOISES
___HEARING LOSS
___EAR DISCHARGE
___NOSE PAIN
___NOSE BLEEDING
___NOSE DISCHARGE
___DIFFICULT BREATHING THRU NOSE
___SORE GUMS
___DENTAL PROBLEMS
___SORE MOUTH
___HOARSENESS
___DIFFICULT SPEECH

CARDIO/VAS/RESPIRATORY
___CHEST PAIN
___DIFFFICULT BREATHING
___PERSISTENT COUGH
___COUGHING PHLEGM
___COUGHING BLOOD
___RAPID HEARTBEAT
___B. P. PROBLEMS
___HEART PROBLEMS
___LUNG PROBLEMS
___VARICOSE VEINS

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES SHOWN BELOW.



CHILDHOOD DISEASES: _____

COMPLICATIONS: _____

PRIOR SURGERY: _____

MEDICATION PRESENTLY TAKING: _____

PREVIOUS ACCIDENTS: _____

MOTHER LIVING? ___YES ___NO IN GOOD HEALTH? ___YES ___NO

FATHER LIVING? ___YES ___NO IN GOOD HEALTH? ___YES ___NO