

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 /Pager: _____ 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 : _____

Number of Children: _____ Names and ages of children: _____

Your Occupation: _____ Your Employer _____

Employer's Address _____ Employer's Number (____) _____

Weight Frequently Required to lift is Under 10 20 30 40 Lbs: _____

Referred to this office by: TV Screening Where? _____

Dex Yellow Pages Mountain Communities Pages Canyon Courier Clinic Location Letter Health Journal

Post Card Flyer Attorney Phone Call MD - Name? _____

One of our Patients or a Friend - 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 OCURRED: _____

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 ADDITONAL 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 CICLE 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. Fontana and staff 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 _____