LILBURN
SPORTS & FAMILY
WELLNESS

FOR THE BEST HEALTH OF YOUR LIFE!

Confidential Patient Data

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO BETTER SERVE YOU. PLEASE COMPLETE ALL QUESTIONS. IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

(Fill out forms in Blue or Black ink only)

PATIENT INFORMATION **Today's Date:** _____/_____/_____

Name: _____ **Date of Birth:** _____/_____/_____

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

Home Phone #: _____ **Work Phone #:** _____ **Cell #:** _____

Social Security #: _____-_____-_____ **Age:** _____ **Sex:** ☐ Male ☐ Female

(Social Security # must be provided on all 3rd party accounts which includes billing your insurance)

Email Address: _____ **Driver's License #:** _____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

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

Number of Biological Children: _____ **Number of Adopted Children:** _____

#1. Name: _____ **Age:** _____
☐ Biological ☐ Adopted

#2. Name: _____ **Age:** _____
☐ Biological ☐ Adopted

#3. Name: _____ **Age:** _____
☐ Biological ☐ Ad opted

#4. Name: _____ **Age:** _____
☐ Biological ☐ Adopted

Name of Spouse or Nearest Relative: _____ **Phone #:** _____

Your Occupation: _____ **Your Employer:** _____

Referred to this Office by: ☐ Friend/Family Member- Name? _____ ☐ Yellow Pages

☐ Clinic Location ☐ Insurance Company ☐ Google ☐ Website ☐ Other_____

Whom may we contact in case of emergency?

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Pt. #: _____

Patients Name: _____ **Date:** _____/_____/_____

MEDICATIONS

MEDICATION HISTORY (*Please write 'none' or 'N/A' if this question does not apply)*

Medication Name	For What Medical Condition	Dosage/Mg/Mcg	Per Day
1.			
2.			
3.			
4.			
5.			

Are you allergic to any medications? ☐ No ☐ Yes, what kind? _____

Are you taking any herbs/supplements? ☐ No ☐ Yes, what kind? _____

MEDICAL HISTORY

SURGICAL HISTORY (*Please write 'none' or 'N/A' if this question does not apply)*

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Have you ever had any type of implant? ☐ No ☐ Yes, what kind? _____

Have you ever sustained a gunshot wound? ☐ No ☐ Yes, where? _____

Accident History:

(Please write 'none' or 'n/a' if this question does not apply):

☐ Job ☐ Auto ☐ Other 1. _____ **Date:** ____/____/_____

☐ Job ☐ Auto ☐ Other 2. _____ **Date:** ____/____/_____

☐ Job ☐ Auto ☐ Other 3. _____ **Date:** ____/____/_____

Have you ever been in an industrial injury or any other injury for which you received treatment? ☐ Yes ☐ No
If so, when?

_____

Pt. #: _____

Patients Name: _____ **Date:** _____/_____/_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms **(1-10, with 1 being least serious)**

(Area of Complaint)	**(Rate 1-10)**
1._____	_____
2._____	_____
3._____	_____

Symptoms developed from: ☐Job related injury ☐Auto Accident ☐Other ☐Accident ☐Illness ☐Unknown

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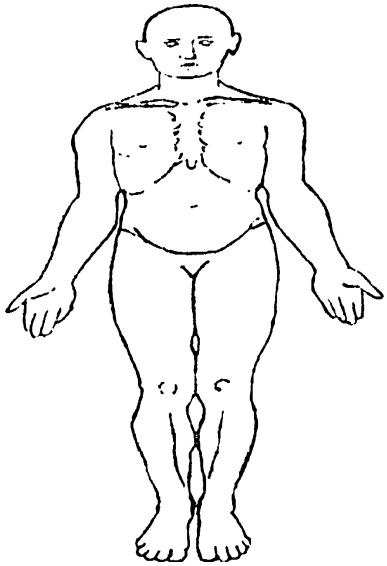
Onset: ☐Gradual onset ☐Sudden onset **Date occurred:** _____/_____/_____

To help us better communicate with you, please check the best answer
(ONLY CHOOSE ONE PER QUESTION)

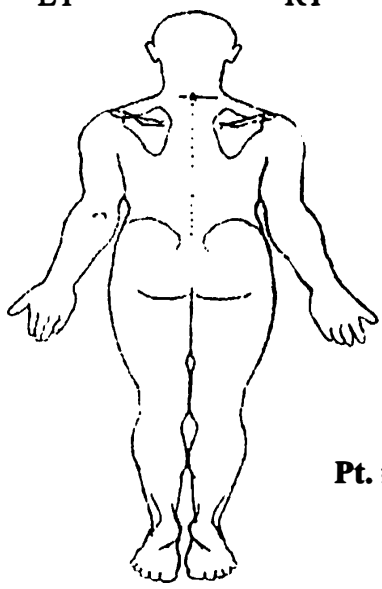
1. I remember important things in my life by:
   ☐ What I see ☐ What I hear ☐ What I feel
2. The primary reason I brush my teeth is to:
   ☐ Avoid tooth decay and gum disease ☐ Make sure I have healthy teeth and gums
3. When I make decisions I generally:
   ☐ Gather facts and weigh the evidence ☐ Make the right choice instantly
   ☐ Consult my friend and family ☐ Depends upon how I "feel" about it

Please mark an X on the anatomy man below to indicate where you have pain or other symptoms.

RT LT



LT RT



Pt. #_____

Patients Name: _____ **Date:** _____/_____/_____

Please check the following activities that aggravate your condition:

☐Bending ☐Reaching ☐Straining at stool ☐Coughing ☐Sitting ☐Turning head

☐Lifting ☐Sneezing ☐Lying down ☐Walking ☐Standing ☐None

Please check the following activities that relieve your condition:

☐Bending ☐Sitting ☐Lying down ☐Standing ☐Lifting ☐Turning head

☐Reaching ☐Walking ☐None

WOMEN ONLY: **Date of last menstrual cycle:** _____/_____/_____

(Check all that apply)

☐Painful period ☐Spotting ☐# of pregnancies_____

☐Premenstrual symptoms ☐Irregular periods ☐# miscarriages _____

☐Vaginal discharge ☐Lumps in breast ☐# of deliveries_____

☐Last pap _____ ☐Hot flashes

Are you pregnant? ☐No ☐Yes, due date: ____/____/_____

FAMILY MEDICAL HISTORY

FAMILY	CONDITION	FAMILY	CONDITION	FAMILY	CONDITION
☐	ADD/ADHD	☐	Depression	☐	Muscular dystrophy
☐	AIDS/HIV/ARC	☐	Diabetes	☐	Neck pain
☐	Allergies	☐	Dislocated joints	☐	Nervousness
☐	Alzheimer's	☐	Epilepsy	☐	Numbness
☐	Alcohol/drug abuse	☐	German measles	☐	Polio
☐	Anemia	☐	Headaches	☐	Poor circulation
☐	Anxiety	☐	Heart Condition	☐	Reproductive disorders
☐	Asthma	☐	Heart Disease	☐	Rheumatic fever
☐	Arthritis	☐	Hepatitis	☐	Rheumatism
☐	Autism	☐	High/low blood pressure	☐	Scarlet fever
☐	Back pain	☐	High/Low Blood Sugar	☐	Scoliosis
☐	Bladder trouble	☐	High/low Cholesterol	☐	Seizure
☐	Bone fracture	☐	Indigestion	☐	Serious Injury
☐	Bowel control loss	☐	Kidney disorder	☐	Sickle Cell Disease
☐	Cancer	☐	Menstrual cramps	☐	Sinus trouble
☐	Chest pain	☐	Mental Illness	☐	Stroke
☐	Concussion	☐	Migraines	☐	Tuberculosis
☐	Convulsions	☐	Multiple sclerosis	☐	Venereal Disease

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: _____/_____/_____

Pt. #: _____

Patients Name: _____ **Date:** _____/_____/_____

SELF OR PATIENT HEALTH REVIEW QUESTIONAIRE

(Please check all that apply)

Skin/Hair/Nails
- ☐Eczema
- ☐Itchy skin
- ☐Dry scalp
- ☐Hair loss
- ☐Oily scalp
- ☐Rough, scaly skin
- ☐Dry skin
- ☐Oily skin
- ☐Psoriasis
- ☐Yellowing skin
- ☐Bruise easily
- ☐Paper thin nails
- ☐Pale skin
- ☐Nail biting
- ☐Baldness

Eyes
- ☐Blurring of vision
- ☐Double vision
- ☐Eyes fatigue easily
- ☐Periods of blindness in one eye
- ☐Excessive (or) ☐Lack of tearing
- ☐Light sensitive eyes
- ☐Excessive itching
- ☐Pain in eyeball

Ears
- ☐Loss of hearing
- ☐Pain in ears
- ☐Discharge from ears
- ☐Vertigo
- ☐Ringing in ears

Nose Nasopharynx Sinuses
- ☐Unusual nasal discharge
- ☐Nose bleeds
- ☐Pressure over eyes
- ☐Pressure under eyes
- ☐Obstruction of nose
- ☐Frequent colds
- ☐Sinusitis / Sinus trouble
- ☐Nasal allergies / Allergies
- ☐Loss of sense of smell

Mouth & Throat
- ☐Pain in mouth
- ☐Pain in throat
- ☐Bleeding gums
- ☐Cavities
- ☐Abscessed teeth
- ☐Dentures
- ☐Difficulty swallowing
- ☐Changes in voice

Respiratory
- ☐Shortness of breath
- ☐Cannot breathe laying down
- ☐Cannot sleep lying down
- ☐Dry cough
- ☐Productive cough
- ☐Coughing up blood
- ☐Wheezing

Gastrointestinal
- ☐Poor appetite
- ☐Constant ribbing
- ☐Difficulty swallowing
- ☐Indigestion
- ☐Cannot eat some foods
- ☐Nausea and vomiting
- ☐Jaundice
- ☐Abdominal pain
- ☐Bowel habit change/control loss
- ☐ Diarrhea
- ☐Constipation
- ☐Hemorrhoids

Venereal Disease
- ☐HIV/AIDS
- ☐Chlamydia
- ☐HPV
- ☐Syphilis
- ☐Gonorrhea
- ☐Herpes
- ☐Hepatitis
- ☐Other: _____

Genitourinary
- ☐Frequent urination
- ☐Infrequent urination
- ☐High (or) ☐Low urine volume
- ☐Kidney disorder
- ☐Disrupted sleep due to need to urinate
- ☐Intense desire to urinate
- ☐Difficulty starting urination
- ☐Dribbling urine
- ☐Blood in urine
- ☐Cloudy urine
- ☐Lack of bladder control
- ☐Abdominal pain

Social History
- ☐Smoking – ☐Currently (or) ☐ Past
- ☐Other tobacco use
- ☐Alcohol - ☐Currently (or) ☐ Past
- ☐Drink coffee/tea/sugary beverages

Diet is:
- ☐Balanced
- ☐Not balanced

Rest is:
- ☐Sufficient
- ☐Not sufficient

Family Stress is:
- ☐Severe
- ☐Moderate
- ☐Minimal
- ☐None

School Stress is: (If applies)
- ☐Severe
- ☐Moderate
- ☐Minimal
- ☐None

Pt. #: _____

Patients Name: _____ **Date:** _____/_____/_____

Job Stress is:
☐Severe
☐Moderate
☐Minimal
☐None

Nervous System
☐Nervousness
☐Irritability
☐Fatigue
☐Depression
☐Anxiety
☐Generally run-down
☐Crave sweets
☐Crave salt
☐Paralysis
☐Forgetfulness
☐Fainting Spells
☐Headaches/Migraines
☐Jerking muscles
☐Convulsions
☐Dizziness with (or) ☐without nausea
☐Concussion
☐Insomnia

Cardiovascular
☐General swelling
☐Swelling in legs
☐Swelling in face
☐Swelling around eyes
☐Chest pain
☐Pounding heartbeat
☐Blue/purple skin
☐Blue/purple nail beds
☐Fainting
☐Hypertension

Vertibrobasilar
☐Memory loss
☐Loss of coordination
☐Irregular muscle movement
☐High (or) ☐Low blood pressure
☐High (or) ☐Low cholesterol
☐High (or) ☐Low blood sugar
☐Heart Attack
☐Irregular heartbeat
☐Hardening of the arteries
☐Muscle weakness
☐Heart Disease
☐Heart Condition
☐Epilepsy
☐Seizure
☐Stroke
☐Diabetes ☐Type 1 (or) ☐Type 2
☐Poor Circulation
☐Muscular dystrophy
☐Numbness – Area: _____
☐Arthritis – Area: _____
☐Previous neck or head injury
☐Inability to form words
☐Currently on birth control
☐Area of abnormal sensations (burning)
☐Blood vessel disease

Musculoskeletal System
☐Broken bones (or) ☐ Fractures
☐Hip pain
☐Trouble walking
☐Weak muscles
☐Arm problems
☐Sore muscles
☐Swollen joints
☐Painful joints
☐Stiff joints

Low Back
☐Low back pain
☐Feels out of place
☐Muscle spasms

Mid Back
☐Mid back pain
☐Pain between shoulder blades
☐Sharp stabbing pain
☐Dull ache
☐Pain from front to back
☐Pain over the kidneys
☐Muscle spasms

Shoulders
☐Pain in shoulders (right/left)
☐Pain across shoulders
☐Tension in shoulders
☐Muscle spasms
☐Can't raise arm over shoulder
☐Can't raise arm over head

Neck
☐Pain in neck
☐Neck pain with movement
☐Swelling in neck
☐Stiff neck
☐Pinched nerve in neck
☐Neck feels out of place
☐Muscle spasms
☐Grinding sound in neck
☐Popping sound in neck
☐Limited neck movement

Extremities
☐Pain in upper arms
☐Pain in forearms
☐Pain in hands
☐Pain in fingers
☐Numbness in fingers
☐Cold ☐Hands (or) ☐Feet
☐Swollen/sore joints in fingers
☐Loss of grip strength
☐Pain in buttocks
☐Pain in knees
☐Pain going down legs
☐Leg cramps
☐Numbness in legs
☐Swollen feet/ankles
☐Numbness in toes

_____