Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date:_____

Name: _____ Home Phone:_____

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

Age:_____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address:_____

Please Check Type of Payment: ☐ Cash ☐ Check ☐ MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

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

Office Phone: _____ Cell Phone: _____ Your SS#: _____

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company: _____

Insurance Plan/Group#: _____ Your Work Hours: _____

Do You Have Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer:_____ Occupation: _____

Office Phone: _____ Cell Phone: _____Spouse's SS#:_____

Describe The Major Complaints That Bring You To Our Office: _____

_____

_____

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ ***Date:*** _____

Guardian's Signature (For Minors): _____***Date:*** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Health Review

Please Check All Present Symptoms:

Skin, Hair, Nails
( ) Eczema
( ) Itchy skin
( ) Rough, scaly skin
( ) Dry skin
( ) Oily skin
( ) Yellow skin
( ) Bruise easily
( ) Baldness
( ) Paper thin nails
( ) Nail bitting

Eyes
( ) Blurred vision
( ) Double vision
( ) Eye fatigue
( ) Excessive tearing
( ) Lack of tearing
( ) Light bothers eyes
( ) Excessive itching
( ) Pain in eyeball

Ears
( ) Loss of hearing
( ) Not sufficient
( ) Pain in ears
( ) Discharge from ears
( ) Vertigo
( ) Ringing in ears

Nose & Sinuses
( ) Nose bleeds
( ) Pressure over eyes
( ) Nose obstruction
( ) Frequent colds
( ) Sinusitis
( ) Loss of smell
( ) Allergies

Mouth & Throat
( ) Pain in throat
( ) Bleeding gums
( ) Abscessed teeth
( ) Dentures
( ) Difficulty swallowing

Respiratory
( ) Shortness of breath
( ) Dry cough
( ) Coughing up blood
( ) Wheezing
( ) Productive cough

Gastrointestinal
( ) Poor appetite
( ) Constant nibbling
( ) Difficulty swallowing
( ) Indigestion
( ) Nausea & vomiting
( ) Abdominal pain
( ) Change in bowel habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids

Genitourinary
Urination is
( ) Frequent
( ) Not sufficient
The amount is
( ) High
( ) Moderate
( ) Low
( ) Frequent urination at night
( ) Intense desire to urinate
( ) Difficulty urinating
( ) Lack of control
( ) Pain with urination
( ) Dribbling
( ) Bloody urine
( ) Cloudy urine

Venereal Disease
( ) Syphilis
( ) Gonorrhea
( ) Other

Women Only
( ) painful periods
( ) spotting
( ) premenstrual symptoms
( ) irregular periods
( ) lumps in breast
( ) vaginal discharge
# of pregnancies _____
# of deliveries _____

Social History
( ) Smoking
( ) Other tobacco use
( ) Alcohol use
( ) Drink coffee or tea
Diet is
( ) Balanced
( ) Not balanced
Rest is
( ) Sufficient
( ) Not sufficient
Recreation is
( ) Sufficient
( ) Not sufficient
Family stress is
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None
My job stress is
( ) Severe
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Panic attacks
( ) Problems sleeping
( ) Generally feel run-down

Musculoskeletal System

Please Check All Present Symptoms:

Head
( ) Frequent headaches
( ) Severe headaches
( ) Head feels heavy
( ) Vertigo
( ) Dizziness
( ) Light headedness
( ) Loss of taste
( ) Loss of smell
( ) Loss of hearing
( ) Loss of balance

Neck
( ) Pain in neck
( ) Pain with movement
( ) Swelling in neck
( ) Stiffness in neck
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding sounds in neck
( ) Popping sounds in neck
( ) Limited neck movement

Mid-Back
( ) Mid-back pain
( ) Pain between shoulder blades
( ) Sharp stabbing pain
( ) Dull ache
( ) Pain from front to back
( ) Pain over kidney area
( ) Muscle spasms

Lower Back
( ) Lower back pain
( ) Lower back feels out of place
( ) Muscle spasms

Shoulders
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
( ) Can't raise arm
( ) Above shoulder
( ) Above head

Arms & Hands
( ) Pain in upper arm
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
( ) Pins & needles
( ) In arms
( ) In fingers
( ) Fingers go to sleep
( ) Cold hands
( ) Swollen fingers
( ) Loss of grip strength

Hips, Legs & Feet
( ) Pain in buttocks
( ) Pain in hip
( ) Pain down leg
( ) Knee pain
( ) Leg cramps
( ) Pins & needles in legs
( ) Numbness in legs
( ) Numbness in toes
( ) Cold feet
( ) Swollen ankles
( ) Swollen feet

Health History

Name: _____ Date: _____

List All Current Health Problems:

_____

_____

List Any Other Doctors Seen, Treatments And Results Obtained:

_____

_____

Your Current Physician(s)/Therapist(s):

_____

List All Surgeries And Their Dates:

_____

_____

List Any Medications You Are Taking:

_____

_____

List Any Traumas And Their Dates:

_____

_____

Please Check The Conditions You Have Or Have Had:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) Venereal disease

Please Check All Present Symptoms:

CARDIOVASCULAR

( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heart beat
( ) Irregular heart beat
( ) Blue or purple skin
( ) Blue or purple nail beds
( ) Cold hand/feet

VERTEBROBASILAR

( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Ringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Stroke
( ) Hypertension
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Check if you smoke
( ) Fainting
( ) Area of numbness

Coordination of Care

Patient: _____

(Print Name Please)

In an effort to provide the highest quality of care I would like Upper Cervical Health Centers to coordinate care with the following parties:

(Add Name & Check all that apply)

- ☐ **Primary Care Physician:** _____
- ☐ **Orthopedist:** _____
- ☐ **Physical Therapist:** _____
- ☐ **Podiatrist:** _____
- ☐ **Dentist:** _____
- ☐ **Other:** _____

I understand that by signing below I am giving Dr. Knecht and Upper Cervical Health Centers- Fort Myers permission to contact and send my notes, records and/or imaging to the above checked health care providers that are part of my health care team. I understand that this is not a guarantee that the above mentioned health care providers will read or respond to said records but is an effort to coordinate care to provide superior care for the patient.

Patient: _____ **Date:** _____

(Signature of Patient/Parent if minor) (Ex: 00/00/0000)