Confidential Patient Information

Valerie Lynn Vogel, DC
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(503) 244-1330

Patient Name ____ Date ________________

Address ____
Street number City State Zip

Circle preferred phone: Home ________________ Work ________________ Mobile ______________

Birth date __________________ Email ____

Occupation ____ Calls at work OK? Yes/ No

Partner/Spouse/Emergency Contact ____________________________ Phone __________________

Referred by ___________________________________ May I thank them for referring you? Yes / No

____

Purpose for this appointment (major complaint)____

____

____

Symptoms developed from: Work injury ____ Auto accident ____ Other: ______________________

____

Date developed _______________ Ever had a similar condition? Yes / No When? _______________

____

List activities that aggravate your condition ____

____

____

Is this condition interfering with your work? ____

Sleep? _________________________________ Daily routine? _________________________

Other? ____

Other practitioners consulted for present condition ____

____

If not your current complaint, have you ever had pain in or an injury to your (circle if applicable)
back/neck, ankle/knee/hip, or wrist/elbow/shoulder? Please describe_____________________________

____

Please list any previous auto accidents, falls, head injuries or other significant injuries, with dates ______

____

____

Have you had X-rays recently? Yes / No Ever? Yes / No Location and date __________________

____

List surgical operations with dates ____

____

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Patient Name ____ Date ________________

Date of last physical exam ____________________ Colon or rectal exam ______________________

Prostate exam _______________________ Pap smear/Breast exam____________________

Any abnormal findings for any of the above exams? ____

____

Are you pregnant? Yes / No Due date ________________ Are you trying to get pregnant? Yes / No

Habits/Lifestyle

Occupation (current and past) ____

Hobbies _________________________________ Pets ___________________________________

Travel __________________________________

Age and type of mattress ____

Do you wear foot supports? Yes / No If yes: type and age __________________________________

Alcohol intake _______________ Cigarettes ________________ Recreational drugs _____________

Do you exercise daily? ________ 3-5 times per week? ________ Occasionally? __________________

What type of exercise do you do? ____

____

Do you eat a special diet? Yes / No How so? ____

____

Do you believe you eat well? Yes / No If not how do you believe you should change your diet? ______

____

List any medications you are taking (prescription, over the counter, herbs, homeopathy) _____________

____

____

List any vitamins/minerals you are taking (attach sheet if necessary) ____________________________

____

____

Family Health History

Are you adopted? Yes / No

Please list any significant diseases or illnesses, for example, diabetes, heart disease, cancer, etc.:

Mother: Living / Deceased ____

Father: Living / Deceased ____

Siblings: Living / Deceased ____

Living / Deceased ____

Living / Deceased ____

Living / Deceased ____

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Patient Name ____ Date ________________

Chief (major) complaint ____

Onset

Describe what you were doing or have been doing to cause this injury____________________________

____

Provoking

What activities/positions aggravate this condition? (please circle) sitting / standing / lying down / sleeping / walking / reaching / bending / other ____

Palliative

Does anything make it feel better? (please circle) ice / heat / sleep / laying down / aspirin / stretching / other ____

Quality

How would you describe the pain? (please circle) sharp / electric / burning / stabbing / grabbing / aching / deep / other____

Radiation

Please circle any areas you have sensations radiating (traveling) into, if any: arm / forearm/ hand / buttock / thigh / leg / foot / shoulder blade / other ____

Please circle the way you would describe these radiating sensations, if any: sharp pain / dull pain / tingling / numbness / prickly / other ____

Severity

Rate your pain on a scale of 0 – 4, with 0 being no pain and 4 being constant pain that prevents ALL activities. 0 1 2 3 4

Pattern

Do you notice any particular pattern to your pain? most painful (please circle):

in the morning / in the evening / after working / after rest / other __________________________

Any other complaints or health problems? ____

____

____

____

____

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Please check any of the following you currently experience or had as past problems. Dates?

Head

_____ Headache
_____ Allergies
_____ Dizziness
_____ Ringing or other noises in the ear(s)/Tinnitus
_____ Loss of balance
_____ Fainting
_____ Eye pain
_____ Failing Vision
_____ Jaw joint, TMJ/TMD
_____ Nosebleeds
_____ Sinus infection

Abdomen

_____ Difficulty digesting
_____ Abdominal pain or cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in bowel function
_____ Change in urinary function
_____ Hemorrhoids/bleeding

Chest

_____ Chest pain
_____ Difficulty breathing
_____ Asthma
_____ Breast problems

Other Systems

_____ Fatigue
_____ Sleep issues
_____ Nervousness/Anxiety
_____ Depression
_____ Fever
_____ Change in menstruation or cycle
_____ Abnormal sensation or numbness
_____ Loss of strength or function
_____ Other pain

Other Symptoms

____
____
____
____

Please give a date or initial date of diagnosis for any of the following you have had.

_____ Alcoholism
_____ Allergy
_____ Anemia
_____ Appendectomy
_____ Arteriosclerosis
_____ Arthritis
_____ Cancer
_____ Colitis
_____ Diabetes
_____ Diphtheria
_____ Eczema
_____ Emphysema
_____ Epilepsy
_____ Gall bladder problems
_____ Goiter
_____ Gout
_____ Heart disease
_____ Hepatitis
_____ HIV/AIDS
_____ Hypertension/High blood pressure
_____ Infections
_____ Kidney stone/infection
_____ Liver problems
_____ Malaria
_____ Migraine headaches
_____ Multiple sclerosis
_____ Pelvic inflammatory disease
_____ Pleurisy
_____ Pneumonia
_____ Polio
_____ Pregnancy
_____ Prostate problems
_____ Scarlet fever
_____ Sexually transmitted disease
_____ TIA/Stroke
_____ Thyroid problems
_____ Tuberculosis
_____ Ulcers
_____ Whooping cough
_____ Other ___________________________
_____ Other