CONFIDENTIAL PATIENT INFORMATION

PATIENT DATA

NAME _____ PHONE (____)_____WORPHONE(____)_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____ M / F MARITAL STATUS_____ NUMBER OF CHILDREN _____

DRIVER LICENSE # _____EMAIL ADDRESS _____ SOCIAL SECURITY# _____

OCCUPATION _____ EMPLOYER _____

SPOUSE/RELATIVE NAME _____ RELATIONSHIP_____PHONE # (____)_____

PRESENT COMPLAINT

☐ HEADACHE	☐ NECK PAIN	☐ LT / RT SHOULDER PAIN	OTHERS_____
☐ DIZZINESS	☐ SHOULDER BLADE PAIN	☐ LT / RT ARM PAIN	
☐ NAUSEA	☐ UPPER BACK PAIN	☐ LT / RT ELBOW OR HAND PAIN	_____
☐ NERVOUSNESS	☐ MID BACK PAIN	☐ LT / RT HIP OR LEG PAIN	
☐ RINGING IN EARS	☐ LOW BACK PAIN	☐ LT / RT KNEE OR ANKLE PAIN	_____
☐ SHORTNESS OF BREATH	☐ RIB PAIN	☐ LT / RT FOOT PAIN	

☐ CHEST PAIN ☐ NUMBNESS TO HANDS OR FEET _____

MEDICAL HISTORY_____

☐ POLIO	☐ DIABETES	☐ REUMATISM	☐ SCARLET FEVER	☐ DIGESTIVE DISODERS
☐ ANEMIA	☐ HEPATITIS	☐ CONCUSSION	☐ HEART TROUBLE	☐ HIGH BLOOD PRESSURE
☐ ASTHMA	☐ ARTHRITIS	☐ CONVULSIONS	☐ GERMAN MEASLES	☐ MUSCULAR DYSTROPHY
☐ CANCER	☐ DIZZINESS	☐ NERVOUSNESS	☐ RHEUMATIC FEVER	☐ HEADACHES
☐ NEURITIS	☐ NUMBNESS	☐ TUBERCULOSIS	☐ VENEREAL DISEASE	☐ CARPAL TUNNEL
☐ EPILEPSY	☐ BACKACHES	☐ SINUS TROUBLE	☐ MULTIPLE SCLEROSIS	☐ OTHER_____

PREVIOUS CARE

SURGERIES ☐ YES ☐ NO WHERE_____WHEN _____

TREATED BY A PHYSICIAN FOR ANY CONDITION IN THE LAST 12 MONTHS? ☐ YES ☐ NO

WHAT_____

DESCRIBE CONDITION_____ DATE OF LAST PHYSICAL EXAM _____

ALLERGIC TO ANY MEDICATION ☐ YES ☐ NO WHAT KIND?

_____

PREGNANT ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD

List your current medication _____

_____

_____

INSURANCE

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ _____

INSURANCE COMPANY_ _____ _____GROUP NO _____

PATIENT'S AGREEMENT

I, assign all rights under my policy to the following doctor or facility Kien Ta DC. Inc. I ask that all checks due to me under policy to be made out to the doctor or facility mentioned. I hereby authorize Kien Ta DC. Inc. to release any information necessary to insurance carriers regarding my illness and treatments: process insurance claims generated during examination or treatment: and allow a photocopy of my signature to be used to process insurance claims for the period of this lifetime

PATIENT'SSIGNATURE_____ DATE _____

GUARDIAN'S SIGNATURE_____ DATE _____