Confidential Patient Information

Today's date:____________ Name:____

What you like to be called:______________ Age: ___ Work phone #:_________________________________

Cell phone #: __________________________________

Address:______________________________________

____Birth date:_____________________________________

____Email Address:_________________________________

Who referred you to us?____

Profession and/or Main Life Activity:____

Employer (including address):____

Previous occupations/activities: ____

Emergency Contact: Name:________________________ Their relationship to you:____________________

Their home and work phone numbers:____

Informed Consent: I know that I have the right to ask any question I need to about the procedures offered by Dr. Russell and that I can refuse any treatment he suggests. Dr. Russell and I will work together on a diagnosis of my condition how to address it, I agree to work in cooperation with Dr. Russell to educate myself about my condition and make responsible, informed choices about my health. I can ask for alternatives to Dr. Russell's care, if interested. Dr. Russell's care may not be what I need; so I understand that Dr. Russell may need to refer me to another practitioner, either to work together with him or in his place. Finding the best way to assist my healing process is our number one consideration.

Signature:____ Date:

Main Complaint

What is your major complaint today?____

____

How long have you had this problem?____

Have you had this problem before? Yes__ No__ When and how often?_______________________

What helps this condition?____

What makes it worse? ____

Is it getting worse? Yes ___ No ___ Constant ___ Comes and Goes _____

Does this condition interfere with your work?____ Sleep?____ Daily routine?_____ Other _____

How long has it been since you felt really good?___________________________________

Has anyone else treated you for this condition? (If yes, explain):_________________________

____

Do you have any other complaints/symptoms today?__________________________________

____

History of Medical Care

List any surgeries you have had and the dates of surgery:______________________________

____

____

Have you ever been advised to have a surgical procedure which has not been performed? (Please explain)

____

Date of last physical exam:________ Doctor's name and City:___________________________

Drugs you now take (prescription or non-) and what they're for:

____

____

____

____

____

____

____

____

Illnesses

Please check any condition you have ever had.

___ Bone/joint disease
___ Arthritis/Rheumatism
___ High/low blood pressure
___ Sexually transmitted disease
___ Anemia
___ Epilepsy (seizures/fits)
___ Migraine Headaches
___ Chronic Fatigue Syndrome
___ Cancer (type?___________)
___ Psychiatric illness
___ Depression
___ Asthma
___ Thyroid problems
___ Shingles (herpes zoster)
___ HIV infection
___ Hernia
___Gout
___ Prostate problems
___ Stroke
___ Artificial bones/joints
___Chemical/drug dependency
___ Lyme Disease
___ Suicidal thoughts
___Scoliosis
___ Anxiety
___ Fibromyalgia
___ Autoimmune Disorder

Do you have allergies? (List)____

Have you been in a motor vehicle accident? ____ past year ___ past 5 years ___ over 5 years

Describe ____

____

Have you ever had any ___ broken bones ___ sprains ___ dislocations ___ concussion/head injury

Have you ever been knocked unconscious?____

Do you have any other concerns or history Dr. Russell should be aware of? ______________________________

____

____

Check any problem you have had in the last year.

___ chronic/persistent cough

___ shortness of breath on climbing one flight of stairs

___ swelling of hands/feet

___ braces (on your teeth)

___ numbness, tingling or weakness in hands

___ swelling, redness or heat in a joint

___ dental problems

___ vision problems

___ pain behind your eyes

___ wear glasses (last checkup date? __________)

___ difficulty hearing/ringing in ears

___ hay fever

___ varicose veins

___ change in hair/skin texture

___ sensitivity to hot and cold

___ snoring

___ anorexia/bulimia

___ loss of urine on coughing, sneezing,

___ trembling/twitching

___ TMJ/jaw pain

___ grinding your teeth

___ frequent/severe headache

___ fainting/dizziness

___ earaches/ear discharge

___ easy bruising or bleeding

___ Sinus trouble

___ dry skin

___ brittle/weak nails

___ cold hands/feet

For women:

When was your last pelvic exam? _______ Findings? _________________________________

When was you last PAP test? ___________ Findings?_________________________________

When was your last mammogram?_______________ Findings?__________________________

Do you perform a self breast exam? _____ How often? ________ If not, why not?___________

____

Is your period regular? ___ Do you get PMS? _____

Are you peri-menopausal? ___ Post-menopausal? ____

Are you pregnant?_______

Have you ever been pregnant? ___ If so:

Have you ever had a Caesarean section? ________

Have you ever had an abortion or miscarriage? _____

Family History:

Has anyone in your family ever had these problems? If so, what is their relationship to you?

Cancer	____________________		
Heart trouble	____________________	High blood pressure	__________________________
Stroke	____________________	Epilepsy	__________________________
Mental illness	____________________	Suicide or attempt	__________________________
Osteoporosis	____________________	Alcoholism	__________________________
Asthma	____________________	Scoliosis	__________________________
Diabetes	____________________	Other major illness	__________________________

Family health:

	(If living)		(If deceased)	
	Age	health status?	Age at death	Cause
Mother	___	________________	___	__________________________
Father	___	________________	___	__________________________

Brothers and Sisters:

Name:

__________	___	________________	___	__________________________
__________	___	________________	___	__________________________
__________	___	________________	___	__________________________
__________	___	________________	___	__________________________

Spouse or Partner:

Name:

__________	___	________________	___	__________________________

Children:

Name:

__________	___	________________	___	__________________________
__________	___	________________	___	__________________________
__________	___	________________	___	__________________________
__________	___	________________	___	__________________________

Social History/Lifestyle:

Living situation: ___ alone ___ with partner(s) ___ with family _____ with others If you have children, do they live with you? ____ Do you have pets? What kind? ____________________ Do you have a religious or spiritual practice of any kind? (Include prayer/ meditation, yoga, etc.) If so, describe it briefly:____ In the past year, what have been your major stresses?____

____

How would you describe your mood in general?

___ Happy ___ Content ___ Depressed ___ Anxious ___ Elated ___Hopeless

Do you smoke? ___ Did you ever smoke? ____ How many packs a day/week? ______________

How old were you when you started smoking? ___ When did you stop (if applicable)? _________

What is your weekly consumption of alcohol? ____

Have you ever tried to cut down on your drinking? _____________________________________

How old is your mattress?:_________ Is it comfortable?_______

What position(s) do you sleep in (include position of pillows and arms!)______________________

____

Do you wear: heel lifts _____ Prescription ____ Orthotics ____

Do you ever wear shoes with heels higher than 1 inch?_________

Do you exercise?_____ Describe the physical activities you do and how often you do them:

____

____

____

Insurance

Dr. Russell doesn't belong to any insurance group. If you plan to file for insurance reimbursement:

I hereby give the office of George Russell permission to transmit medical records to insurer.

Signature:____

Date of Birth: _______________________________________

Medicare eligible patients: Dr. Russell does not participate with Medicare. If you are Medicare-eligible, you will need to sign a waiver indicating that you understand that you will not be billing his services to Medicare. If you cannot sign this waiver, Dr. Russell will refer you to another provider.

I have read the previous paragraph and understand: _______________________________________

Diet

What foods do you eat most often?____

Check any food that you eat at least twice a day:

___ Red meat, fish, poultry, or eggs

___ White bread, potatoes, or white rice

___ Dairy products (milk, cheese, yogurt, etc.)

___ Home-cooked food

___ Fruit

___ Green vegetables (including salad)

___ tofu or beans

___ Whole grains or whole grain bread

___ Potato chips, pretzels, or corn chips

___ Restaurant or fast food

___ Sugar (include sugar in drinks)

How much water do you drink daily (no. of 8 oz. glasses, including seltzer/club soda)? ______

Vitamins/Supplements you now take:____

____

I understand the above questions and guarantee that this form is completed correctly to the best of my knowledge. I know that Dr. Russell will rely on this information as part of his evaluation and treatment plan for me and I understand that it is my responsibility to inform this office of any changes in my health status.

Patient's signature:_______________________________ Date:____________

Guardian's signature:______________________________ Date:____________