Confidential Patient Data

Today's Date: _____

Name:_____Birthday:____/_____/_____ Were you born ☐Male ☐Female?
Street:_____ City,State:_____ Zip:_____
Phone: Cell:_____Work: _____ext:_____ Home:_____
E-mail: _____ Preference to contact: ❑Home ❑Work ❑Cell ❑E-mail ❑Any
Occupation:_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widowed ☐Other _____
Emergency Contact Name: _____ Phone:_____

Referred by:_____☐Friend/Family ☐Doctor ☐Ins. Co. ☐Google ☐Website ☐Other_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	numbness
☐	☐	☐	allergies	☐	☐	☐	epilepsy	☐	☐	☐	polio
☐	☐	☐	anemia	☐	☐	☐	fibromyalgia	☐	☐	☐	osteoporosis
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	poor circulation
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	reproductive disorders
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	rheumatic fever
☐	☐	☐	bladder trouble	☐	☐	☐	hepatitis	☐	☐	☐	rheumatism
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	scarlet fever
☐	☐	☐	cancer	☐	☐	☐	high cholesterol	☐	☐	☐	scoliosis
☐	☐	☐	chest pain	☐	☐	☐	HIV/ARC	☐	☐	☐	serious injury
☐	☐	☐	concussion	☐	☐	☐	kidney disorder	☐	☐	☐	sinus trouble
☐	☐	☐	constipation	☐	☐	☐	bowel control loss	☐	☐	☐	stroke
☐	☐	☐	convulsions	☐	☐	☐	lung disease	☐	☐	☐	thyroid disorder
	☐	☐	deceased	☐	☐	☐	menstrual cramps	☐	☐	☐	ulcers
☐	☐	☐	depression	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	diarrhea	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease
☐	☐	☐	diabetes	☐	☐	☐	neck pain				
☐	☐	☐	digestive disorders	☐	☐	☐	nervousness	☐	☐	☐	_____

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_____
Are you pregnant? ☐NO ☐YES
Current Weight: _____ Do you consider yourself?: ☐Underweight ☐Overweight ☐ Just right

SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
3._____ Date:_____
Have you ever had a metal implant? ☐Yes ☐No

ACCIDENT HISTORY: ☐ Job ☐Auto ☐Other Date:_____ Describe:_____
☐ Job ☐Auto ☐Other Date:_____ Describe:_____

Are you taking any **medications**? ☐NO ☐YES If yes, list below. If list is extensive, please ask for additional paper.

List:_____ For: _____
_____ For: _____
_____ For: _____
_____ For: _____

(Please also complete reverse page) 7/2022

LIST YOUR SYMPTOMS (*in ORDER OF SEVERITY):*

(1)**MAIN** SYMPTOM_____

	Presently:	1	2	3	4	5	6	7	8	9	10
Circle Level of	At best:	1	2	3	4	5	6	7	8	9	10
Severity:	At worst:	1	2	3	4	5	6	7	8	9	10

(2)_____Severity: 1 2 3 4 5 6 7 8 9 10

(3)_____Severity: 1 2 3 4 5 6 7 8 9 10

(4)_____ Severity: 1 2 3 4 5 6 7 8 9 10

When did your symptoms start?_____

When do you feel the symptoms? □MORNING □AFTERNOON □NIGHT □It VARIES □It's CONSTANT

Symptoms developed from: □Work Injury □Auto Ax. □Sports □Unknown □Gradual Onset □Other:_____

Symptoms have persisted for # _____HOUR(S) _____DAY(S) _____WEEK(S) _____MONTH(S) _____YEAR(S)

What SINGLE ACTIVITY of daily living is MOST affected by this problem? (for example: sitting)_____

To what degree is this problem affecting your daily activities? □Mildly □Moderately □Severely

Have you had this complaint before? □NO □YES WHEN?_____

DOCTORS PREVIOUSLY SEEN FOR THIS CONDITION (AND WHEN):

_____

_____

What activities aggravate your condition? □BENDING □REACHING □STRAINING OF BOWEL
□COUGHING □SITTING □TURNING HEAD □LIFTING □SNEEZING
□WALKING □LYING DOWN □STANDING □OTHER(S)_____

What relieves your condition? □BENDING □SITTING □LIFTING □STANDING □LYING DOWN
□TURNING HEAD □REACHING □WALKING □NOTHING
□OTHER(S): _____

Patient Signature: X_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

John Jaeger, D.C.
3883 Route 516
Old Bridge, NJ 08857

I understand that I have the right to refuse to sign this acknowledgement.
I have read the Notice of Privacy Practices for the above referenced practice.

_____ X_____ _____

PRINT NAME PATIENT SIGNATURE DATE