

Primary Health Concerns

Who is your primary care physician? (Doctor and/or practice) _____

PLEASE ADDRESS WHAT BRINGS YOU TO OUR OFFICE:

Health concerns list According to severity	Rate of Severity 1=Mild 10= Severe	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Please check to indicate if you are currently or have ever experiencing any of the following conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins/Needles in Legs |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fractures | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Gout | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Sleeping Difficulties |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sudden Weight Loss |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Low Body Temp | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Cold Feet/Hands | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pinched Nerve | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins/Needles in Arms | |

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- | | |
|---|--|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Autoimmune _____ | <input type="checkbox"/> Neurological Diseases _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes _____ | |

Primary Health Concerns continued...

Received A Diagnosis For ANY Condition By Another Health Care Provider? Y N

If Yes, What Was the Diagnosis? _____

Who Provided the Diagnosis? _____

Medication Name	Dosage	Reason

Supplement Name/Brand	Dosage	Reason

Please list any allergies: _____

Do you use birth control? Yes _____ No _____ What Type?

Do you exercise: Frequently Moderately Occasionally None

Does your work activity mostly involve?
 Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:
 Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Have you ever been exposed to mold? Yes _____ No _____

Have you ever been exposed to chemicals (work/home, ex: pesticides, lead, etc.)? Yes _____ No _____

Sleep/Rest:

Average number of hours you sleep: _____ more than 10 _____ 8 to 10 _____ 6 to 8 _____ less than 6

Do you have trouble sleeping? Yes _____ No _____

Do you have problems falling asleep? Yes _____ No _____

Do you have problems staying asleep? Yes _____ No _____

Do you feel rested upon awakening? Yes _____ No _____

Do you have problems with insomnia? Yes _____ No _____

Do you snore? Yes _____ No _____ Do you use sleeping aids? Yes _____ No _____

Dental History:

Do you have (or had) any non-tooth colored fillings (ie silver or gold colored fillings)?

Yes _____ No _____ How many _____

Have you had any fillings removed? Yes _____ No _____

Do you have any root canals? Yes _____ No _____ How many? _____

Other dental fixtures? Yes _____ No _____ Describe _____

Have you had any dental work in the last 12 months? Please describe.

Is there anything else you would like Dr. Singh to know?

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

Patient's Signature

Date