Skylyn Wellness Center, inc 1770 Skylyn Dr, Spartanburg, SC 29307

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____

Name: _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____Work Phone: _____Cell: _____

If we need to contact you regarding an appointment, which phone number do you prefer we use? HOME WORK CELL

Social Security #:_____ Age:_____ ❑ Male ❑ Female

Email:_____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance ❑Automobile Insurance ❑Worker's Compensation

How were you referred to our office?:Friend/Family Member:_____ O Insurance O Internet Search O Family Doctor: _____ O Other? _____

Name of Insurance Co: _____Insured's Employer: _____

Insured's Social Security #:_____ Employer's Phone #:_____

Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal dis.

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

Do you smoke? ❑Yes ❑No If yes, how much? _____packs/day

Do you use smokeless tobacco? ❑Yes ❑No

ACCIDENT HISTORY : ❑Job ❑Auto ❑Other 1._____ Date:_____

❑Job ❑Auto ❑Other 2._____Date:_____

❑Job ❑Auto ❑Other 3._____Date:_____

(over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, **with 1 being least serious**)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT
WHEN AND HOW OCCURRED?_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES IF YES, WHAT KIND?_____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING
❑ICE ❑HEAT

WHAT IS LIMITED BY YOUR CONDITION, HOW IS YOUR LIFE AFFECTED, WHAT DO YOU HAVE TROUBLE WITH?
❑SLEEP ❑LEISURE ACTIVITIES ❑WORK/JOB ❑PLAYING WITH CHILDREN ❑EXERCISE ❑READING
❑HOUSEWORK ❑WALKING ❑READING ❑DRIVING ❑OTHER/S_____

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation
❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever
❑headaches ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds
❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins & needles in legs
❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset ❑insomnia ❑head seems too heavy

Patient's Signature: _____ Date:_____