

PATIENT INFORMATION SHEET

Name: _____ **Date:** _____ **Sex:** M / F

Full Address: _____

Home Phone #: _____ **Work Phone #:** _____

Date of Birth: _____ **Age:** _____ **Email:** _____

Have you attended a seminar of Dr. Macdonald's? _____ **Do you have extended health coverage?** _____

Premium Assistance Yes _____ No _____ **Care Card#** _____

How did you hear about us? _____

Medications: _____

Present Complaint: _____

Pain or problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with your work? ____ Sleep? ____ Daily Routine? ____ Other? _____

Is condition getting progressively worse? _____

Have you seen any other Doctors or therapists seen for this condition, what did you have done and did it help? _____

Are you taking and medications for this condition? _____

Have you had any surgeries that relate to this condition? _____

Other Symptoms:

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Pins and Needles in legs	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Pins and Needles in Arms	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	Numbness in Fingers	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Numbness in Toes	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Feet Cold
<input type="checkbox"/>	Tension	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Hands Cold
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Stomach Upset
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Lights Bothers Eyes	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	Cold Sweats

