Dr. Eric Fair DC
430 Victoria Rd • Newton • KS • 67114

PATIENT INFORMATION

Today's date:	**Primary Care Physician:**

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid / Sig Other

Is this your legal name? ☐ **Yes** ☐ **No**	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security No. :	Home phone no. : ( )
		Cell phone no. : ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no. : ( )

Chose clinic because / Referred to clinic by (please check one box):

☐ Dr. Referral ☐ newspaper ☐ Hospital ☐ Family/Friend ☐ TV ☐ Dinner Event ☐ Mailer
☐ Other

Email:	Spouse's Name:

Please List any other family members/friends involved in your health decisions:

We often find our patients have the desire to help others suffering from nerve damage. List other family members/friends who's lives would improve with understanding of their condition:

Name:	Phone Number:

Insurance Name:	☐ PPO ☐ HMO ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone no. : ( )	Work phone no. : ( )
The above information is true to the best of my knowledge. *Patient/Guardian signature:* *Date:*			

316-804-7095

Patient Name: ______________________________ Today's Date: ____________

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Personal History

Check all conditions that apply to you:

General	Neurological	Psychiatric	Respiratory
□ Fatigue, tiredness □ Weakness □ Chills □ Fever □ Night sweat □ Appetite change □ Lived in foreign country □ Unexplained weight loss □ Unexplained weight gain □ Generalized pain □ Unable to tolerate heat □ Unable to tolerate cold □ Sedentary lifestyle □ Active lifestyle □ Other ______________	□ Fainting spells □ Seizures □ Paralysis □ Dizziness □ Tremor □ Chronic headaches □ Poor balance □ Fractured back or neck □ Numbness of face / arm / leg □ Peripheral neuropathy □ Stroke or Mini – stroke □ Other ____________________	□ Depression □ Anxiety (abnormal) □ Panic attacks □ Alzheimer's □ Confusion (abnormal) □ Hospitalized for nervousness □ Substance abuse □ Anorexia □ Other ______________	□ Chronic obstructive disease □ Wheezing □ Chronic cough □ Coughing up blood □ Asthma □ Shortness of breath □ TB □ Lung Cancer □ Emphysema □ Chronic bronchitis □ Pneumonia □ Fluid in lungs □ Need to sleep sitting up □ Other __________________
Cardiac	**Vascular**	**Gastrointestinal**	**Genitourinary**

□ Angina (chest pain)
□ Rapid heartbeat
□ Past heart attacks
□ Heart murmur
□ Congestive heart failure
□ High blood pressure
□ Aortic aneurysm
□ Other heart problem
□ **Pacemaker**
□ **Defibrillator**
□ Other________________
	□ Leg pain walking over 1 block
	□ Leg pain walking less than 1 block
	□ Pain in legs while at rest
	□ Blood clots in legs
	  □ Deep
	  □ Superficial
	□ Cold feet or hands
	□ Amputation of toes
	□ Amputation of feet or legs
	□ Peripheral vascular disease
	□ Ulcers of lower legs
	□ Varicose viens
	□ Aneurysm of arteries
	□ Other ____________________
		□ Diarrhea
		□ Constipation
		□ Stool changes
		□ Bowel habits changes
		□ Hemorrhoids
		□ Indigestion
		□ Ulcers
		□ Irritable bowel
		□ Colon polyps
		□ Cramps/ pains
		□ Cancer of the stomach or bowel
		□ Diverticulitis
		□ Other ______________________
			□ Hesitancy / urgency of urine
			□ Need to urinate often at night
			□ Loss of bladder control
			□ Difficult urination
			□ Renal failure
			□ Impotence
			□ Current Dialysis
			□ Renal transplant
			□ Prostate enlargement
			□ Cancer of bladder/ kidneys
			□ Other ______________________

Blood & Lymph System	**Eyes, Ears, Nose & Throat**	**Musculoskeletal**	**Skin**
□ Anemia □ Blood disease □ Transfusions □ Leukemia □ Bone marrow test □ Long term Coumadin use □ Blood clotting problems □ Other ______________	□ Pain □ Hearing loss □ Polyps □ Vertigo □ Ringing in ears (tinnitus) □ Sinus infections □ Deafness □ Other ________________	□ Arthritis □ Joint swelling □ Joint stiffness □ Muscle aches □ Muscle weakness □ Leg cramps □ Other _________________	□ Rashes □ Tumors □ Sensitivity to sunlight □ Malignant melanoma □ Squamous cell carcinoma □ Basal cell carcinoma □ Easy bruising □ Fungal infections □ Non-healing sores □ Excessive rough or dry skin □ Other __________________
Endocrine	**Abnormal Organs**		
□ Thyroid problems □ **Diabetes – Type 1** □ **Diabetes – Type 2**	□ Hepatitis □ Cirrhosis (Liver) □ Gallbladder disease	Height: _________________ Weight: _________________	

Medications – Please list all medications you are currently taking:

Name	Dosage	Name	Dosage

If you need additional space, Please use the back of this page.

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Patient Name: ______________________________ Today's Date: ____________

What is your major complaint?

____

____

____

How long have you had this problem?

____

____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ☐ Yes ☐ No If so please describe:

____

____

____

What have you tried for treatment that did not work?

____

____

Have you seen a M.D. , P.T. , or a D.C. for this problem?
☐ Yes ☐ No

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

____

____

____

Have you been worried about getting this problem resolved?
☐ Yes ☐ No If yes, please describe:

____

What is your main concern about your symptoms?

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

	0	1	2	3	4	5	6	7	8	9	10