## 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

Todayla Data:

Social Security #:	I ATILITI INI ORIVIA	TION		Tod	ay's Date:_	
Work Filding	Name:			Date o	of Birth:	
Work Filding	Address:		Citv:		State:	Zip:
Male   Female   Fem	HOITIE I HOITE.		vvork Phone	3.	Cell.	
Social Security #:	if we need to contact you regard	ding an appointment, v	which phone nu	mber do you prefer w	ve use? Ho	OME WORK CELI
Married   Single   Divorced   Separated   Other   Name of Spouse or Nearest Relative:   Phone:   Pho	Social Security #:			_Age:		
Name of Spouse or Nearest Relative:	Email:					
Name of Spouse or Nearest Relative:	Marital Status:   Marrie	d Single	Divorced	Separated	□Other	
Automobile Insurance   Worker's Compensation   How were you referred to our office?:Friend/Family Member:	Name of Spouse or Nea	rest Relative:		F	Phone:	
Automobile Insurance   Worker's Compensation   How were you referred to our office?:Friend/Family Member:	Your Occupation		Y	our Employer		
Automobile Insurance   Worker's Compensation   How were you referred to our office?:Friend/Family Member:	Payment for Services wi	ll be by: □Cas	h DCheck	Credit Card	□Health In	Isurance
How were you referred to our office?:Friend/Family Member: 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?		ΠΔιite	mohila Inci	Iranco	MMorkor's	Componention
Name of Insurance Co:	How were you referred t	o our office? Fri	end/Family	Member	- vvoikei s	O Incurance
Name of Insurance Co:	O Internet Search O F	amily Doctor	Charl alliny	O Ot	hor?	O insulance
MeDical   Michael   Mich	Name of Insurance Co:	army Doctor		Incured's	Employer:	
MeDical   Michael   Mich	Insured's Social Socurity	, #-		Employer's Dhe	Employer	
MeDical   Michael   Mich	Are you covered by mor	γ than one incu	anaa aama	anu? DVaa DN	le Neme	
Clease indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).    S	RAEDICAL (FARALLY)	UCTODY	ance comp	any? Lites Lin	Name	
S         M         F         S         M         F         neck pain         neck pain         nervousness         nervousness         nervousness         numbness         numbness         numbness         polio         polio         polio         poor circulation         perproductive disorders         polio         poor circulation         perproductive disorders         perproductiv	WEDICAL/FAMILY F	115 T ORY	<u>S</u> = Self	<u>IVI</u> = 1	Wother	$\underline{F}$ = Father
anemia	(Please indicate which PAST co	nditions have been ex				propriate boxes).
anemia		<u>s</u> <u>n</u>	! 늘		S M F	
arthritis				cated joints		neck pain
asthma     headaches   polio   poor circulation   heart trouble   heart fever   heart trouble   heart fever			STATE OF THE PERSON NAMED IN COLUMN TWO			
back pain       heart trouble     poor circulation   hepatitis   hepatit						numbness
	Procedure to the second			laches		polio
bone fracture   high blood pressure   rheumatic fever   rheumatic fever   high blood pressure   rheumatic fever   rheumatic fever   high blood pressure   rheumatic fever   rheumatic fever   heumatic fever   heumatic fever   heumatic fever   heumatic fever   scarlet fever   sc	□ □ □ back pain		hear	t trouble		poor circulation
	□ □ □ bladder troub	ole 🔲 🗀	☐ repro	ductive disorders		hepatitis
		e 🔲 📮		blood pressure		rheumatic fever
	□ □ □ cancer		☐ HIV/			rheumatism
	□ □ □ chest pain		☐ kidne	ey disorder		scarlet fever
			□ bow	el control loss		
			☐ men	strual cramps		OF THE RESIDENCE OF THE PARTY O
□ □ indigestion □ □ muscular dystrophy □ □ venereal dis.  Have you been treated by a physician for any health condition in the last year? □Yes □No  Describe Condition	WHO I WHO I WHO I WAS A SHOULD NOT THE WAS A SHOULD					
Have you been treated by a physician for any health condition in the last year?						
Describe Condition	mangeetten			salar ayon opiny		vonorodi dio.
SURGICAL HISTORY:           1	Have you been treated by a	physician for any he	ealth condition	in the last year?	□Yes □No	
SURGICAL HISTORY:           1	Describe Condition			Date of Las	t Physical Ev	am
1	SURGICAL HISTORY:	One of the William Control of the Co		Date of Las	ot Thysical Ex	am
2					Date	
ACCIDENT HISTORY:  Date:	2.				Date	
Have you ever had a metal implant?	3				Date	
Do you smoke?						
ACCIDENT HISTORY :						
□Job □Auto □Other 2Date:	Do you use smokeless tob	oacco? □Yes	□No			
□Job □Auto □Other 2Date:	ACCIDENT LISTORY	□ lob □ Auto	Other 1			Date:
	ACCIDENT HISTORY					
LIJOD LIAUIO LIVINEL 3. DATE:						
(over please)						Date

PLEASE DESCRIBE PRESENT MAJOR COMPLAIN IS:  Please Rate Your symptoms(1-10, with 1 being least serious)
1
2
3
4
5
SYMPTOMS ARE WORSE IN MORNING DAFTERNOON DIGHT WHEN AND HOW OCCURRED?
SYMPTOMS DEVELOPED FROM: DOB RELATED INJURY DAUTO ACCIDENT DOTHER DACCIDENT DILLNESS DUNKNOWN CAUSE DGRADUAL 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: UNO UYES 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
ARE YOU PREGNANT UNO UYES DATE OF LAST MENSTRUAL PERIOD
PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:  BENDING PREACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD  LIFTING SNEEZING WALKING LYING DOWN STANDING
PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:  BENDING DISTRING STANDING STANDING 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 □ 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 □ stomach upset □ insomnia □ head seems too heavy
Patient's Signature: Date: