

**Demographic Sheet**

\_\_\_\_\_  
Last Name (Patient Information)      First                      Middle                      Social Security Number

\_\_\_\_\_  
Home Address                      Apt #                      City                      State                      Zip

\_\_\_\_\_  
Date of Birth      Age      Marital Status                      Home Phone                      Cell Phone

\_\_\_\_\_  
e-mail address                      Emergency contact name/Relationship                      Phone

\_\_\_\_\_  
Employer name/School attending      (circle)                      Address

\_\_\_\_\_  
City                      State                      Zip                      Phone

\_\_\_\_\_  
Spouse/partner/parent/guardian Last name                      First name                      Middle initial

\_\_\_\_\_  
Social Security Number      Sex      Date of Birth      Age      Work phone                      Cell phone

\_\_\_\_\_  
Insurance Company                      Address                      City                      State                      Zip

\_\_\_\_\_  
Insurance Phone Number                      ID Number                      Group Number

\_\_\_\_\_  
Name of insured                      Relationship                      Date of birth of insured

\_\_\_\_\_  
Address of insured                      City/State/Zip                      Phone

I hereby authorize Dr. Edward P. Tyson, to furnish information to insurance carriers concerning this illness, as required by the insurance carrier and as defined in the previously provided paperwork outlining Dr. Tyson's office policies and procedures. **As a reminder, payment is due in full at time of service as we do not accept any insurance.**

\_\_\_\_\_  
Signature                      Date                      Parent or guardian if patient is a minor                      Date

**First Visit Information**

Your name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Why did you come to see Dr. Tyson today?  
\_\_\_\_\_

How did you hear about Dr. Tyson? \_\_\_\_\_

Are you in school? \_\_\_\_\_ If so, where? \_\_\_\_\_

Are you working? \_\_\_\_\_ If so, what is your job? \_\_\_\_\_

Any long range plans?

With whom do you live? \_\_\_\_\_ Both natural parents \_\_\_\_\_ Spouse  
\_\_\_\_\_ Mother \_\_\_\_\_ Stepmother  
\_\_\_\_\_ Father \_\_\_\_\_ Stepfather  
\_\_\_\_\_ Alone \_\_\_\_\_ Roommate  
\_\_\_\_\_ Other: Explain: \_\_\_\_\_

Have there been any changes in your immediate family, such as:

\_\_\_\_\_ Marriage \_\_\_\_\_ Births \_\_\_\_\_ Deaths  
\_\_\_\_\_ Divorce \_\_\_\_\_ Loss of job \_\_\_\_\_ Move to new house  
\_\_\_\_\_ NO CHANGES

What would you like to change about your life?  
\_\_\_\_\_

List any and all medications (including 'over-the-counter' meds) that you are taking and the problem for which the medicine is taken:

Medicine: \_\_\_\_\_ Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all allergies to medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all hospitalizations, their dates, and for what problems below:

Dates: \_\_\_\_\_ Reason: \_\_\_\_\_ Problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Questionnaire**

Below are listed a number of common problems. Circle YES or NO to each question. This information is STRICTLY CONFIDENTIAL. Hand this sheet directly to the doctor or nurse. This information will not be shown or given to any one else, unless you specifically request to do so.

- |   |     |    |
|---|-----|----|
| 1. Do you think there is something wrong with your health?  | YES | NO |
| 2. Are you often upset?   | YES | NO |
| 3. Do you have trouble falling asleep or waking up during the night?  | YES | NO |
| 4. Do you think you are overweight or underweight?  | YES | NO |
| 5. Are you doing well in school (if applies)?   | YES | NO |
| 6. Are you having difficulties at home?   | YES | NO |
| 7. Were you adopted?  | YES | NO |
| 8. Have you ever lived in foster care or an institution?  | YES | NO |
| 9. Are you bothered by severe headaches?  | YES | NO |
| 10. Are you bothered by stomachaches or stomach problems?   | YES | NO |
| 11. Are you bothered by dizzy spells?   | YES | NO |
| 12. Do you think you are too short or too tall?   | YES | NO |
| 13. Do you have trouble making friends?   | YES | NO |
| 14. Do you think there is something wrong with your head or brain?  | YES | NO |
| 15. Are you unhappy with your skin (complexion)?  | YES | NO |
| 16. Do you think something is wrong with your ears or hearing?  | YES | NO |
| 17. Do you think something is wrong with your eyes?   | YES | NO |
| 18. Do you think something is wrong with your breathing?  | YES | NO |
| 19. Does it burn or hurt when you go to the bathroom?   | YES | NO |
| 20. Have you had any urinary or kidney infections?  | YES | NO |
| 21. Do you have high blood pressure?  | YES | NO |
| 22. Do you have muscle or joint pain?   | YES | NO |
| 23. Do you have allergies?  | YES | NO |
| 24. Are you worried you might have cancer?  | YES | NO |
| 25. Have you fainted or passed out lately?  | YES | NO |
| 26. Do you have chest pain?   | YES | NO |
| 27. Do you smoke cigarettes?  | YES | NO |
| 28. Do you smoke joints?  | YES | NO |
| 29. Do you drink alcohol?   | YES | NO |
| 30. Do you have any bad habits you would like to get rid of?  | YES | NO |
| 31. Are you troubled by your future plans?  | YES | NO |
| 32. Are you so sad sometimes you think about dying or hurting yourself?   | YES | NO |
| 33. Are you concerned you might have an STD?  | YES | NO |
| 34. Do you have any other personal problems that you would like to discuss with the doctor but rather not write down? | YES | NO |

35. How good is your health?

1	2	3	4	5	6	7	8	9	10
									GREAT
TERRIBLE									

36. How do you get along with your parents/spouse (if applicable)?

1	2	3	4	5	6	7	8	9	10
									GREAT
TERRIBLE									

Date: \_\_\_/\_\_\_/\_\_\_

Any prior history or concerns about Attention Deficit Hyperactivity Disorder (ADHD)?

\_\_\_\_\_  
\_\_\_\_\_

When was your last visit to the dentist? \_\_\_\_\_

Were there any problems that needed treatment? If so, what were they?

**FEMALES:**

How old were you when your periods began? \_\_\_\_\_

When was your last period? \_\_\_\_\_

About how often do you have a period? \_\_\_\_\_

How long do they usually last? \_\_\_\_\_

Do you have cramps with your period? YES NO

How do you treat the cramps? \_\_\_\_\_

Have you ever lost your period for 3 or more months? YES NO

Have you ever had an abnormal Pap smear? YES NO

If so, when and how was it treated?

\_\_\_\_\_

Have you ever had a significant vaginal discharge or been treated for female disorders? YES NO

Have you ever been told that you have an STD or treated for one? YES NO

Do you think you might be pregnant? YES NO

Have you ever been pregnant? YES NO

Are you using birth control? YES NO

If so, what kind?

**Diet History**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please list any and all food that you actually ate during the 24-hour period yesterday (even if you purged after eating it). If you ate after midnight the day before yesterday, that, would count in yesterday's food.

Quantify the amounts as accurately as possible. Please note that there is a separate column for fluids (this includes any liquids, such as water, milk, shakes, etc.).

Foods	Quantity	Fluids	Quantity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Exercise History**

Over the last week, how much have you exercised?

Please list the type of exercise, what time of day you do the activity, the duration each time, and the intensity of the workout.

For example, “Wed., 7AM, ran 6 miles at a 7 minute pace.” Or, “Tuesday, bedtime, 200 crunches to fatigue.”  
If no exercise in the past week, then indicate that also.

Day of week	Time of day	Type of exercise	Duration	Intensity
Monday	_____	_____	_____	_____
Tuesday	_____	_____	_____	_____
Wednesday	_____	_____	_____	_____
Thursday	_____	_____	_____	_____
Friday	_____	_____	_____	_____
Saturday	_____	_____	_____	_____
Sunday	_____	_____	_____	_____

**Current Symptoms**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

The following is a list of symptoms or complaints you may or may not have. Please read each one and check any and all items that apply, even if they may not have changed since your last visit. **This is CONFIDENTIAL.** Please fold it over when done and hand it to the therapist or receptionist when you are ready to be seen.

- \_\_\_\_\_ Feeling cold much of the time
  - \_\_\_\_\_ Fingers or toes turn blue at times
  - \_\_\_\_\_ Having “hot flashes” or sweating spells (at night or other times not related to exercise)
  - \_\_\_\_\_ Dizziness or feeling like you’re going to pass out at times
  - \_\_\_\_\_ Your mouth feels dry at times
  - \_\_\_\_\_ Chew gum frequently
  - \_\_\_\_\_ Your heart beat going fast suddenly
  - \_\_\_\_\_ Feeling your heart “skip beats” or like it “jumps” at times
  - \_\_\_\_\_ Chest pain
  - \_\_\_\_\_ Shortness of breath or trouble breathing recently
  - \_\_\_\_\_ Difficulty thinking straight or remembering things as well recently
  - \_\_\_\_\_ Trouble falling or staying asleep
  - \_\_\_\_\_ Swelling in your feet or hands
  - \_\_\_\_\_ Stomach hurting some
  - \_\_\_\_\_ Blood when you have thrown up or gone to the bathroom
  - \_\_\_\_\_ Noticing something that looks like coffee grounds when you have thrown up
  - \_\_\_\_\_ Cutting on yourself some
  - \_\_\_\_\_ Pain in one or more of your bones (like your shin or feet) or joints
  - \_\_\_\_\_ I have thrown up at least once recently
  - \_\_\_\_\_ I have taken some laxatives recently
  - \_\_\_\_\_ I have taken some diet pills recently
  - \_\_\_\_\_ I have taken stuff to make me throw up
  - \_\_\_\_\_ I have taken some water pills recently
  - \_\_\_\_\_ I have been drinking alcohol enough to get drunk recently
  - \_\_\_\_\_ I have taken other stuff that I would rather not talk about
  - \_\_\_\_\_ I have thought about hurting or killing myself recently
- \_\_\_\_\_ About how many calories a day have you been eating for the last week (on average)
- \_\_\_\_\_ I have no idea how many calories I have been eating (check here if you cannot answer the above question).
- \_\_\_\_\_ About how much fluid (water, milk, etc.) have you consumed in the last day? Give an idea of the amount in either ounces, cups, or 8 oz. glasses).