Patient Information **Today's Date** ________________

Patient's Legal Name ________________________________ Nickname ______________
(First) (Middle) (Last)

SSN ____________________ Date of Birth ______________ Age _____ Gender ____________

Marital Status __S__M__W__D__ Race ____________________ Ethnicity ____________________

Address ______________________________ City __________________ State ________ Zip ________

Cell # ______________________ Work # __________________ Home # ____________________

Email ______________________________ Preferred Pharmacy ______________________________

Emergency Contact: Name, Phone Number, and Relationship ______________________________

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Your Occupation ______________________ Employer ______________________________

Primary Insurance __________________________ Secondary Insurance ____________________

Spouse's Name ______________________ Spouse's Cell Phone ________________________

Spouse's SSN __________________ Spouse's Date of Birth __________________

Parent/Guardian Name ______________________________________ DOB ______________

SSN ____________________ Gender ________________ Relationship to patient ______________

Address ____

Phone Number ______________________ Email ______________________________________

Employer ______________________________________ Work Number ______________________

Guarantor Name ____ DOB ______________

SSN ____________________ Gender ________________ Relationship to patient ______________

Address ____

Phone Number ______________________ Email ______________________________________

Employer ______________________________________ Work Number ______________________

Patient Name ____ **Today's Date**_____________

(First) (Middle) (Last)

Height________________ Weight ______________ Rt. Handed _____________ Lt. Handed________________

Who referred you to this office?____________________Primary Care Physician _________________________

Health History

Constitution: General State of Health (Very Good, Good, Fair, Poor), Recent Weight Loss, Fevers, Fatigue

Eyes/Ears: Blindness, Pain, Glaucoma, Wear Glasses/ Contact Lenses, Deafness, Hearing Aid(s)________________

Nose/Mouth: Nosebleeds, Broken Noses, Sinus Infections, False Teeth (upper/lower, partial)

Lungs: Pneumonia, TB, Chronic Cough, Asthma, Shortness of Breath ___________________________

Heart: Chest Pain, Irregular Heartbeat, Rheumatic Fever, Heart Attack, High/Low Blood Pressure_____________

Intestine: Stomach Pain, Jaundice, Vomiting, Blood in Stool, Ulcers, Hernias______________________

G.U.: Difficulty Urinating, Dribbling, Bloody Urine, Frequent Infections, Kidney Stones, Kidney/Renal disease, Diabetes ____

Nervous System: Headaches, Dizziness, Convulsions, Unconsciousness, Loss of Feeling in the arms/legs ________

Psychiatric: Memory Loss, Confusion, Depression, Sleep Problems, Nervousness ___________________

Extremities: Muscle or Joint Pain, Weakness, Leg or Arm Pain, Swelling Joints______________________

Blood: Hepatitis, HIV/AIDS, Anemia, Leukemia, Bleeding Tendencies, Bruise Easily ___________________

Have you ever had blood clots? _______ If yes, where was the clot? ___________________________

Have you or any relative had unusual bleeding problems during or after surgery? ___________________

Have you or any relative had a very high temperature during surgery?______________________

Arthritis: ____

Hematology/Oncology: Hypo or Hyper Thyroid, Cancer (type) ___________________________

Other current health problems or illnesses not listed above: ___________________________

Smoking Yes No Type you use? Cigarettes, Vaping, Pipe, Cigar, Chewing Tabacco ________________

How much per day? ____________________ How Long? ___________________________

Drinking Alcoholic Beverages Yes No Type of beverages? ___________________________

How much per week? ____________________How Long? ___________________________

Hobbies/Recreational Activities? ____

Family History

Please check medical problems present in your immediate family:

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Kidney ☐ Bleeding ☐ Ulcer/ Stomach

☐ Arthritis ☐ Cancer Type __________________________ ☐ Other ___________________________

Current Complaint/ Injury, please specify ☐ Left ☐ Right

☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Foot ☐ Back ☐ Ankle ☐ Other______________

How did it start? ____________________________When did it start? ___________________________

Any Previous Problems? Yes No Any other areas injured? Yes No

List____

Describe Pain Level ☐ 0 (no pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐extreme pain

Frequency of Pain ☐ 0 (none) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐Always

Describe Timing ☐ same always ☐ worse in the mornings ☐ worse at night ☐ gets worse through the day

Cause of Complaint/ Injury

Is this work related? Yes No Date occurred ________/________/__________

How do you feel work caused this problem?____

Where were you when you were hurt? ____

If a work injury or accident, describe how you were injured? ____________________________

SPECIAL NOTE FOR WORK RELATED INJURIES

If this is a work related injury, we are required, by law, to bill your industrial insurance carrier. Should you fail to tell us this is work related until after your personal insurance has been billed, there will be a $100.00 administrative charge to cover reprocessing of charges and refunding of payments that may have been made. This is a charge you will be personally responsible for. It cannot be paid by your personal or industrial company.

Is this auto accident related Yes No Date occurred ________/________/________

Is this sports related? Yes No Which sport? ____________________________________

Have you been treated for this problem? Yes No

Physician ______________________________ City/ State ______________________________

Hospital _______________________________ City/ State ______________________________

(Check any of the following you've had for this problem:

☐ X-Rays ☐ MRI ☐ Injection ☐ CT Scan ☐ Therapy ☐ Surgery

List All Operations ☐ None ☐ Yes (Please List) Tonsils, Wisdom Teeth, Lasik, Cosmetic, Hysterectomy, Gallbladder, Carpal Tunnel, C-section____

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Allergies ☐ None ☐ Yes (Please List) Metal sensitivity ☐ Yes ______________________________

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Current Medications/ Dose/ Frequency ☐ None ☐ Yes (Please List) _______________________

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