

Patient Information

Name _____
Address _____
City/State/Zip _____
Phone _____
DL# _____
SSN _____

Spouse _____
Nearest Relative _____

Employer _____
Address _____
City/State/Zip _____

Referring Physician _____
Family Physician _____
Marriage Status: Married / Divorced / Widowed
Single / Other

Age _____ Birthdate _____
Sex: Male / Female
e-mail address _____
Spouse Work Phone _____
Relative Phone _____

Occupation _____
Work Phone _____

If patient filing under Worker's Comp

Name of Worker's Compensation Ins. _____
Address of Ins.Co. _____
City/State/Zip _____
Current duty status _____

Employer Phone _____
Claim # _____
Is light duty available? Yes / No

If Patient under 18 or lives with Parents

Father's Name _____
Father's Birthday _____
Father's SSN _____
Father's Employer _____
Employer Address _____
City/State/Zip _____
Work Phone _____

Mother's Name _____
Mother's Birthday _____
Mother's SSN _____
Mother's Employer _____
Employer Address _____
City/State/Zip _____
Work Phone _____

Health Insurance

How do you intend to pay for today's visit? Cash / Check / Visa / MasterCard

Name of Responsible Party _____
Was this an Accident? Yes / No
On the Job? Yes / No
Date of Injury _____
Date of previous injury to same body part _____

Which applies to you? (circle):

Medicare _____ Medicaid _____
HMO# _____
Workman's Comp _____ Other _____
PPO _____ Private Pay _____

Primary Insurance

Insured by: Self / Spouse / Parent
Insurance Co. _____
Address: _____
City/State/Zip _____
Insurance Type: Group / Individual
Group # _____
Policy # _____ Cert. # _____
Insured SSN _____
Insured D.O.B. _____
Medicare/Medicaid # _____

Secondary Insurance

Insured by: Self / Spouse / Parent
Insurance Co. _____
Address: _____
City/State/Zip _____
Insurance Type: Group / Individual
Group # _____
Policy # _____ Cert. # _____
Insured SSN _____
Insured D.O.B. _____
Medicare/Medicaid # _____

Patient/Guardian Signature _____

Date: _____

Past Medical History

Primary care physician: _____

Date of last exam: _____

Please check if you have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Childhood diseases | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Urinary infections |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Leg length inequality |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Ankylosing Spondylitis |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatic fever |

If other conditions, please list: _____

Have you had Cortisone injections? Yes / No

How many? _____

Why did you have them? _____

Have you taken Cortisone by mouth? Yes / No

For how long? _____

Why did you take them? _____

Women

Are you pregnant? (circle) Yes / No

At what age did your menstrual cycles begin? _____

Patient Name _____

Date: _____

Surgical History

Please list all surgeries with approximate year according to the categories listed:

Skin / Plastic: _____

Eye: _____

Brain: _____

Ear/Nose/Throat: _____

Cardiovascular: _____

Pulmonary: _____

Abdominal: _____

Female: _____

Male: _____

Spine: _____

Joints: _____

Bones: _____

Other: _____

Social History

Please circle or fill in the blank:

Sex: Male / Female

Marital Status: Married / Single / Divorced / Widowed

Children: Yes / No How many? _____

Have you ever required a blood transfusion? Yes / No Date _____ Number of units _____

Have you ever smoked? Yes / No _____ packs a day for _____ years total If quit, when _____

Do you drink alcohol? Yes / No How many drinks per week? _____

Do you take any recreational drugs? Yes / No Which drugs? _____

Are you a student? Yes / No

What city do you live in? _____

Job description: _____

How long have you been at this job? _____

How do you prefer to describe your ethnic background? _____

Are you a U.S. Citizen? Yes / No

Patient Name _____

Date: _____

Review of Systems

Please circle symptoms

AND

Describe symptoms:

General: recent weight changes, fever, weakness, fatigue, headaches

No problem

Skin: rashes, eruptions, dryness, jaundice, changes in skin/hair/nails, discoloration, swelling

No problem

Eyes: blurred vision, double vision, burning eyes, seeing spots

No problem

Ears/Nose/Throat: soreness/redness of gums, hoarseness, difficulty swallowing, head colds, nasal drainage, obstruction, sinus pain, ear ache, hearing loss, hearing aids

No problem

Musculoskeletal: joint pain, swelling, stiffness, deformity

No problem

Pulmonary: difficulty breathing, asthma, bronchitis, pneumonia, shortness of breath

No problem

Neurological: fainting, blackouts, paralysis, memory loss, dizzy spells

No problem

Cardiovascular: chest pain, rheumatic fever, rapid heartbeat, leg swelling, heart valve problems, varicose veins, heart attack

No problem

Endocrine: fatigue, hot or cold intolerance, excessive sweating, thirst, hunger

No problem

Gastrointestinal: decrease in appetite, nausea, vomiting, diarrhea, constipation, heartburn, hemorrhoids, reflux, blood in stool, ulcers

No problem

Genitourinary: change in urinary frequency, urinary pain, blood in urine, difficulty voiding, incontinence

No problem

Male: hernias, testicular problems, penile problems, impotency, infertility

No problem

Female: vaginal discharge, pain, discomfort

No problem

Hematological/Lymphatic: anemia, easy bruising or bleeding, swollen glands

No problem

Psychological: nervousness, mood swings, insomnia, nightmares, depression, irritability

No problem

Other: _____

Patient Name _____
Date: _____

Family History

Please check if any of the following occur in your family:

- | | |
|---|---|
| <input type="checkbox"/> Childhood diseases | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Secondhand smoke |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Urinary infections |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Leg length inequality |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Ankylosing Spondylitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus |

If other conditions occur in your relatives, please list: _____

Physician Verification: _____

Date: _____

Patient Name _____

Date: _____