WELCOME

Patient Information

Date: _____

Name: _____
Last First MI

Mailing Address: _____

_____

Phone # (Mobile)_____ (Home)_____ (Work) _____

Can we call you at work? ❑ Yes ❑ No

Email address: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Home Phone #: _____

Phone #: (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Health History

Who is your primary care physician? (doctor and/or practice) _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hypertension	❑ Migraines	❑ Stents
❑ Arthritis	❑ Chemotherapy	❑ Immune Disorders	❑ Osteoporosis	❑ Stroke
❑ Asthma	❑ Diabetes	❑ Implants	❑ Pacemaker	❑ Tuberculosis
❑ Bleed/Bruise Easily	❑ Fractures	❑ Kidney Disease	❑ Pinched Nerve	❑ Vascular Disease
❑ Bleeding Disorders	❑ Heart Disease	❑ Liver Disease	❑ Rheumatoid Arthritis	
❑ Blood Clots	❑ Hepatitis	❑ Lung Disease	❑ Seizures	
❑ Blood Thinner	❑ Herniated Disc	❑ Multiple Sclerosis	❑ Skin Infections/Breaks	
			❑ Other _____	

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

- ☐ Smoker _____packs per day _____Length of time smoking _____ Years since quit
- ☐ Alcohol _____drinks per week _____ number days per week _____other
- ☐ Illicit Drugs _____ type ☐ Currently Using _____Dates started and stopped

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____