

PATIENT INFORMATION

Doctor you are seeing today: _____

PATIENT NAME _____ Appointment Date _____

PLEASE CHECK Male Female ARE YOU: Right Left Handed

MARITAL STATUS D M S W P

BIRTHDATE _____ AGE _____ HEIGHT _____ ft _____ in WEIGHT _____ lbs

OCCUPATION _____

FT / PT / Disabled / Unemployed / Retired / FT Student / PT Student

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend _____ Family Medical Doctor _____

INJURY INFORMATION

Date of injury or accident or onset of symptoms _____ Please list body part below:
Part of body you are being seen for today Left Right Bilateral _____
 Auto Accident? Work Injury?

Describe your injury or the onset of your symptoms

Have you been seen for a previous injury or symptoms for this body part? Yes No
If yes, by whom _____

TREATMENT

Seen in ER? _____ When _____ Where _____
Treatments? Injection Physical Therapy NSAID / Pain Meds Brace
Tests/Scans Done? X-rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV)
Where? _____ Did you bring them with you today? Yes No

PAST MEDICAL HISTORY None

Do you have any of the following medical problems? Please check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Pulmonary Emboli/Blood clots |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Skin Rashes/Psoriasis |
| <input type="checkbox"/> Heart Attack /CAD | <input type="checkbox"/> Lupus/SLE | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer - If you checked off, please tell us what type: _____ | | |
| <input type="checkbox"/> Other (please list) _____ | | |

PAST SURGICAL HISTORY None

Have you ever had surgery? Please check and give the dates to all that apply.

- | | | | | | |
|---|-------------------------|--------------------------------------|----------------------|--|----------------------|
| <input type="checkbox"/> Appendix | <input type="text"/> | <input type="checkbox"/> Bowel/Colon | <input type="text"/> | <input type="checkbox"/> Breast Biopsy | <input type="text"/> |
| <input type="checkbox"/> Gallbladder | <input type="text"/> | <input type="checkbox"/> Gynecologic | <input type="text"/> | <input type="checkbox"/> Heart Surgery | <input type="text"/> |
| <input type="checkbox"/> Hernia Repair | <input type="text"/> | <input type="checkbox"/> Tonsils | <input type="text"/> | | |
| <input type="checkbox"/> Cosmetic Surgery | <input type="text"/> | <input type="checkbox"/> ORTHOPEDIC | <input type="text"/> | | <input type="text"/> |
| | (please list type) | | (please list all) | | <input type="text"/> |
| <input type="checkbox"/> Other | <input type="text"/> | | | | <input type="text"/> |
| | (please list body part) | | | | <input type="text"/> |

MEDICATIONS None

Do you take any of the following medications on a regular basis? Please check all that apply.

- Anti-Inflammatory Aspirin Birth Control Pills Coumadin Tylenol

Please list any prescription medications you are currently taking:

ALLERGIES None

Do you have any **allergies** to any medications? (Please list all that apply & your reaction)

****Do you have an allergy to Latex?*** Yes No

FAMILY HISTORY None

Do your parents, siblings, or grandparents have any of the following? Please check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | | |

SOCIAL HISTORY

(Please check all that apply)

Do you smoke tobacco? Currently: Every day? Or Some days?
 Former Smoker? Never smoked

Do you drink alcohol? No Yes If Yes, how often? ___ Daily ___ Other ___/ week

Have you ever been treated for chemical dependence? No Yes

Education (highest level achieved): High School College Technical School Advanced Degree

Are you pregnant? No Yes

REVIEW OF SYMPTOMS

None

(Please check all that apply)

- | | | | | | |
|------|--|---|---|--------------------------------------|--|
| GI | <input type="checkbox"/> Heartburn, ulcers | <input type="checkbox"/> Nausea, Vomiting | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease |
| ENDO | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heat or Cold Intolerance | | | |
| CON | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Loss of Appetite | | | |
| EYE | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Loss | | |
| ENT | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble Swallowing | | |
| CV | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | | | |
| RS | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of Breath | | | |
| GU | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Kidney Problems | | |
| SK | <input type="checkbox"/> Frequent Rashes | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Lumps | <input type="checkbox"/> Psoriasis | |
| NEU | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizures | | |
| PSY | <input type="checkbox"/> Depression | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Sleep Disorder | | |
| HEM | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Anemia | | |
| ALL | <input type="checkbox"/> Seasonal Allergy | <input type="checkbox"/> Other (please list): _____ | | | |
| LYMP | <input type="checkbox"/> Leg Swelling | | | | |
| MSK | <input type="checkbox"/> Fracture | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Sprains | <input type="checkbox"/> Dislocation | |
| VASC | <input type="checkbox"/> Claudication | | | | |
| MISC | <input type="checkbox"/> Vitamin D/Calcium Supplements | | <input type="checkbox"/> Bone Density Test | | |
- ARE YOU HIV POSITIVE? Yes No

PATIENT DEMOGRAPHICS

Patient Name
Address City
State Zip Code Birth Date Social Security #
Phone #'s: Home Work Cell
Email address OK to email you a Quarterly newsletter Yes No
Employer
Employer's Address/Phone #

Please list your attorney's information (if applicable to this injury):
Name/Address/Phone#:

How did you hear about our practice?: Family/Friend Brochure Yellow Pages Website Other

PRIMARY INSURANCE

Please check one
 Managed Care Private Insurance Medicare School Insurance Self Pay PPO POS HMO
Name of Insurance Plan
Claim Address
Policy # Group #
Subscriber's name Subscriber's home address
Subscriber's home phone # Subscriber's employer
Subscriber's employer address Subscriber's employer phone #
Date of Birth Social Security # Please check one Male Female
Is this insurance coverage through the subscriber's employer? YES NO
Effective date of Insurance

SECONDARY INSURANCE

Please check one
 Managed Care Private Insurance Medicare School Insurance Self Pay PPO POS HMO
Name of Insurance Plan
Claim Address
Policy # Group #
Subscriber's name Subscriber's home address
Subscriber's home phone # Subscriber's employer
Subscriber's employer address Subscriber's employer phone #
Date of Birth Social Security # Please check one Male Female
Is this insurance coverage through the subscriber's employer? YES NO
Effective date of Insurance

**** If this is a workers comp or motor vehicle related injury please complete the information below****

Please check one

WORKERS COMP

MOTOR VEHICLE

Insurance Company

Adjuster/Case Manager Phone #

Address Claim #

Employer

PHARMACY INFORMATION

Please list your pharmacy information

Name
Address
Phone

The Federal Government requires that we obtain the information listed below. Providing us with this information requested below is strictly optional. If you do not want to complete it, please check the box next to "Not Answered". Otherwise please check the box that best describes the category related to you.

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Not Answered

Preferred Language

- Dutch
- English
- French
- Japanese
- Spanish
- Not Answered

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- American Indian or Alaska Native and Black or African American
- American Indian or Alaska Native and White
- Asian and White
- Black or African American and White
- Other
- Not Answered