

**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"/>		
	(please list type)		(please list all)		
<input type="checkbox"/> Other	<input type="text"/>				
	(please list body part)				

**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

**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

**Preferred Language**

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