

**RCVIGP V'PHOTO CVIQP"**

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PATIENT NAME  Appointment Date

PLEASE CHECK  Male  Female ARE YOU:  Right  Left Handed

BIRTHDATE  AGE

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

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**FOEVOT'PHOTO CVIQP"**

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

**PLWI'PHOTO CVIQP"**

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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

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

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

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

<input type="checkbox"/> Tonsils	<input type="text"/>	<input type="checkbox"/> Urinary Tract	<input type="text"/>	<input type="checkbox"/> Gallbladder	<input type="text"/>
<input type="checkbox"/> Gynecologic	<input type="text"/>	<input type="checkbox"/> Breast Biopsy	<input type="text"/>	<input type="checkbox"/> Bowel/Colon	<input type="text"/>
<input type="checkbox"/> Appendix	<input type="text"/>	<input type="checkbox"/> Hernia Repair	<input type="text"/>	<input type="checkbox"/> Heart Surgery	<input type="text"/>
<input type="checkbox"/> Orthopaedic (please list all)	<input type="text"/>		<input type="text"/>		
<input type="checkbox"/> Other	<input type="text"/>		<input type="text"/>		

(please list body part)"

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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:

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**CNNGTI KGU"''""P qpg"**

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

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

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(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):	<input type="text"/>		
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

Last menstrual period?  Problems?

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Are all inoculations up to date?  Yes  No

Birth weight  Type of delivery  Normal  C-section

If C-section, growth and development normal?  Yes  No

Please explain:

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

- Cancer
- High Blood Pressure
- Stroke
- Inherited problems (please list)
- Diabetes
- Osteoporosis
- Heart Disease
- Rheumatoid Arthritis

**Age and Cause of death**

Mother:	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="text"/>
Father:	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="text"/>
Brothers:	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="text"/>
Sisters:	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="text"/>

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(Please check all that apply)

Marital Status:  D  M  S  W  P

Do you smoke tobacco?  No  Yes If Yes, # of cigarettes / packs per day

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

Have you ever been treated for chemical dependence?  No  Yes

Hobbies

Musical Instrument

Sports

# of Children

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

Are you pregnant?  No  Yes

Occupation

Height  Weight  lbs

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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

**RTKQCTI 'KPUWTCPEG'**

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

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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

, , 'K'ij k'k'c'y qt ngt u'eqo r 'qt 'b qvqt 'xgj k'ng't g'rcv'f 'lplwt { 'r'ncug'eqo r'ngv'vj g'lphqt o cvkqp'dgny , , "

Please check one  WORKERS COMP  MOTOR VEHICLE

Insurance Company

Adjuster/Case Manager  Phone #

Address  Claim #

Employer

**RJ CTO CE[ 'PHOTO CVKQP'**

Please list your pharmacy information

Name   
Address   
Phone

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Vj g'Hgf gt cdl qxgt po gpvt'gs wlt gu'vj cv'y g'bdvclp'vj g'lphqt o cvkqp'k'ng'f 'dgny 0'Rt qxl' lpi 'wu'y k'j 'vj k'lphqt o cvkqp'  
t'gs w'ng'f 'dgny 'k'lt l'v'f { 'r'v'k'p'c'f'k' { q'w'f q'p'qv'y cpv'v'q'eqo r'ngv'k'.'r'ncug'ej gen'vj g'dqz 'p'gzv'v'q'd'p'qv' Cpuy gt gf o'0'  
Qvj gt y k'g'r'ncug'ej gen'vj g'dqz 'vj cv'dgu'f g'uet k'dgu'vj g'ecv'gi qt { 't' g'rcv'f 'v'q' { q'w'0'

**G'v'j p'k'k'f** " " " " " **"T'ceg"**

- Hispanic or Latino  American Indian or Alaska Native
- Not Hispanic or Latino  Asian
- Unknown  Black or African American
- Not Answered  Native Hawaiian or Other Pacific Islander

**Rt g'ht t'gf 'N'cpi w'ci g'** " " " **"White"**

- Dutch  American Indian or Alaska Native and Black or African American
- English  American Indian or Alaska Native and White
- French  Asian and White
- Japanese  Black or African American and White
- Spanish  Other
- Not Answered  Not Answered