PATIENT INFORMATION
INITIAL VISIT

TODAY'S DATE

FIRST NAME		MIDDLE NAME	LAST NAME
STREET ADDRESS I APT #			PHONE NUMBER
CITY, STATE, ZIP			CELL PHONE NUMBER
BIRTH DATE	GENDER ○ M ○ F	SOCIAL SECURITY NUMBER	EMAIL ADDRESS
MARITAL STATUS ○ SINGLE ○ MARRIED ○ SEPARATED ○ DIVORCED ○ WIDOWED ○ UNKNOWN			
EMPLOYMENT STATUS ○ FULL-TIME ○ PART-TIME ○ HOMEMAKER ○ UNEMPLOYED ○ FULL-TIME STUDENT ○ PART-TIME STUDENT ○ RETIRED ○ DISABLED			PREFERRED LANGUAGE
EMPLOYER			WORK PHONE NUMBER
EMPLOYER ADDRESS, CITY, STATE, ZIP			
SPOUSE'S NAME		SPOUSE'S EMPLOYER	EMPLOYER PHONE NUMBER

RESPONSIBLE PARTY/ GUARANTOR

PLEASE COMPLETE WITH INSURED PARENT INFORMATION FOR MINORS/SPOUSE.

NAME ○ SELF	RELATIONSHIP TO PATIENT ○ SELF	BIRTH DATE
STREET ADDRESS I APT #		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		PHONE NUMBER
EMPLOYER		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS, CITY, STATE, ZIP		

IF UNDER THE AGE OF 18 PARENT'S/GUARDIAN'S NAME IS REQUESTED.*

MOTHER'S NAME	CELL NUMBER
FATHER'S NAME	CELL NUMBER
GUARDIAN'S NAME	CELL NUMBER

*MINOR CONSENT FORM MUST BE COMPLETED.

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PATIENT INFORMATION *continued*

INITIAL VISIT

PRIMARY INSURANCE

NAME OF INSURANCE	CERTIFICATE/POLICY/ID		GROUP NUMBER	
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT ○ SELF	BIRTH DATE		SOCIAL SECURITY NUMBER

SECONDARY INSURANCE

WORKER'S COMPENSATION/AUTO ACCIDENT PATIENTS, PLEASE LIST PERSONAL INSURANCE AS SECONDARY.

NAME OF INSURANCE	CERTIFICATE/POLICY/ID		GROUP NUMBER	
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT ○ SELF	BIRTH DATE		SOCIAL SECURITY NUMBER

WORKER'S COMPENSATION/ AUTO ACCIDENT

PATIENT IS RESPONSIBLE REGARDLESS OF INSURANCE BENEFITS OR SETTLEMENT.

WC/AUTO/CLAIM #	DATE OF INJURY/ ACCIDENT	HAVE YOU BEEN TREATED FOR THIS INJURY? ○ YES ○ NO
COMPANY/EMPLOYER AT TIME OF ACCIDENT		NOTIFIED YOUR EMPLOYER OF ACCIDENT? ○ YES ○ NO
INSURANCE COMPANY NAME		PHONE NUMBER
ATTORNEY NAME		PHONE NUMBER

SCHOOL/LEAGUE/ REC INSURANCE

NAME OF SCHOOL/LEAGUE/REC	DATE OF ACCIDENT/INJURY

REFERRING AND FAMILY PHYSICIAN INFORMATION

REFERRING PHYSICIAN ○ NONE	PHONE NUMBER
ADDRESS	
FAMILY PHYSICIAN ○ NONE	PHONE NUMBER
ADDRESS	

PATIENT INFORMATION *continued*

INITIAL VISIT

EMERGENCY CONTACT

NAME OF FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT
ADDRESS	PHONE NUMBER

REASON FOR VISIT

WHAT IS THE REASON FOR OUR VISIT TODAY?

LOCATION OF PAIN (INCLUDE SIDE)	ARE YOU RIGHT OR LEFT HAND DOMINANT?	HOW LONG HAS IT BEEN PRESENT?

DESCRIBE PAIN	WHEN DOES PAIN OCCUR?
◯ DULL ◯ SHARP ◯ TINGLING ◯ OTHER:	◯ AT REST ◯ W/ ACTIVITY ◯ AT NIGHT ◯ OTHER:

ANY OTHER SYMPTOMS ASSOCIATED WITH CURRENT PROBLEM?

SEVERITY: ON A SCALE FROM 1-10, INDICATE HOW SEVERE THE PAIN IS — 1 BEING VERY LITTLE TO 10 BEING EXCRUCIATING/CAN'T FUNCTION.

CIRCLE NUMBER: 1 2 3 4 5 6 7 8 9 10

CONTEXT: HOW DID IT OCCUR?

DATE OF INJURY	INDICATE WHAT MAKES IT BETTER
	◯ ICE ◯ HEAT ◯ REST ◯ ELEVATION ◯ NONE

MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS

PLEASE LIST ALL MEDICATIONS, VITAMINS, SUPPLEMENTS AND HERBS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGE IN THE LINES BELOW.

NAME	DOSAGE/AMOUNT	NAME	DOSAGE/AMOUNT

ALLERGIES

PLEASE LIST ALL ALLERGIES AND REACTIONS OR WRITE "NONE" (INCLUDE MEDICATIONS, ENVIRONMENTAL AGENTS, FOOD, OTHER).

ALLERGY	REACTION	ALLERGY	REACTION

PATIENT INFORMATION *continued*

INITIAL VISIT

MEDICAL HISTORY

PLEASE INDICATE MEDICAL CONDITIONS BELOW.

ASTHMA	◯ YES ◯ NO	CLOTTING DISORDER	◯ YES ◯ NO	HEART DISEASE	◯ YES ◯ NO
BLOOD OR PLASMA TRANSFUSIONS	◯ YES ◯ NO	DIABETES	◯ YES ◯ NO	LUNG DISORDER	◯ YES ◯ NO
CANCER	◯ YES ◯ NO	HYPERTENSION	◯ YES ◯ NO	STOMACH/ INTESTINAL DISORDER	◯ YES ◯ NO
CHOLESTEROL	◯ YES ◯ NO	DVT/PE (BLOOD CLOT)	◯ YES ◯ NO	THYROID PROBLEMS	◯ YES ◯ NO
OTHER:					

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES YOU HAVE HAD.

TYPE OF SURGERY	APPROX. DATE	COMPLICATIONS, IF ANY

HAVE YOU EVER HAD GENERAL ANESTHESIA?	HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA?	DESCRIBE
◯ YES ◯ NO	◯ YES ◯ NO	

SOCIAL HISTORY

OCCUPATION		
HOME ◯ 1 STORY ◯ 2 STORY ◯ ENTRANCE STEPS ◯ ELEVATOR	EXERCISE REGULARLY? ◯ YES ◯ NO	INVOLVED IN SPORTS? ◯ YES ◯ NO

ARE YOU A TOBACCO USER?	AVERAGE PER DAY	NUMBER OF YEARS	IF NO, EVER?
◯ CIGARETTES ◯ CIGARS ◯ SMOKELESS TOBACCO ◯ OTHER:			◯ YES ◯ NO

DO YOU CONSUME ALCOHOL?	AVERAGE PER WEEK	IF NO, EVER?	DO YOU CURRENTLY USE DRUGS?
◯ YES ◯ NO		◯ YES ◯ NO	◯ YES ◯ NO

FAMILY HISTORY

PLEASE INDICATE ANY MAJOR CONDITIONS/ILLNESSES FOR FAMILY MEMBERS BELOW.

RELATIVE	**LIVING** (AGE)	**DECEASED** (AGE)	**CAUSE OF DEATH**	**HEALTH PROBLEMS**
MOTHER				
FATHER				
SIBLING				
OTHER				

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INITIAL VISIT

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH YOUR: (IF YES, CHECK BOX TO LEFT OF SYMPTOMS THAT APPLY)

CONSTITUTIONAL	○ YES ○ NO	○ Fatigue ○ Headache ○ Fever ○ Weight Loss ○ Other:
EYES	○ YES ○ NO	○ Glasses ○ Blurred Vision ○ Other:
EARS,NOSE,THROAT	○ YES ○ NO	○ Congestion ○ Hearing Loss ○ Jaw Discomfort ○ Other:
LUNGS, BREATHING	○ YES ○ NO	○ Cough ○ Wheezing ○ Shortness of Breath ○ Other:
HEART	○ YES ○ NO	○ Heart Murmurs ○ Irregular Heartbeat ○ Other:
GASTROINTESTINAL	○ YES ○ NO	○ Nausea ○ Vomiting ○ Stomach Aches ○ Constipation ○ Diarrhea ○ Other:
BLADDER	○ YES ○ NO	○ Incontinence ○ Urinary Tract Infections ○ Difficulty Urinating ○ Other:
ENDOCRINE	○ YES ○ NO	○ Diabetes ○ Thyroid Problems ○ Delays in Growth ○ Other:
MUSCULOSKELETAL	○ YES ○ NO	○ Joint Pain ○ Leg Pain ○ History of Broken Bones ○ Other:
BLEEDING	○ YES ○ NO	○ Anemia ○ Prolonged Bleeding After Cut/Injury ○ Other:
NEUROLOGICAL	○ YES ○ NO	○ Dizziness ○ Numbness/tingling ○ Headaches ○ Frequent Falls ○ Other:
INTEGUMENTARY	○ YES ○ NO	○ Rashes ○ Skin Disorders ○ Connective Tissue Disorders ○ Other:
PSYCHIATRIC	○ YES ○ NO	○ Change in Mood or Behavior ○ Change in Sleep Patterns ○ Other:
IMMUNOLOGIC/ ALLERGIC	○ YES ○ NO	○ Asthma ○ Hay Fever ○ Chronic Rashes ○ Communicable Diseases ○ Other:

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that [am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered.

SIGNATURE: PATIENT OR AUTHORIZED REPRESENTATIVE	DATE
PHYSICIAN'S INITIALS	DATE