

WELCOME

Patient Information

Full Name _____
Address _____

Mailing Address _____
E-Mail _____
Phone _____ Cell Phone _____
Sex: M F Age _____ Birthdate _____
Patient SS# _____
Occupation _____
Employer _____
Employer Phone _____
May We Call You At Work? _____
Spouse's Name _____
Occupation _____
Spouse's Employer _____
Health Insurance Yes No Company _____
Insured's Name _____
Insured's SS # & Date of Birth _____
Insurance ID# _____
Group# _____ Coverage Date _____
How were you referred to our office? Please specify,
Doctor _____ Family/Friend _____
Other _____

Accident/Injury History

AUTO, date(s) & brief description:

WORK, date(s) & brief description:

OTHER, date(s) & brief description:

Broken bones/Dislocations: (Dates):

Medical History

Surgeries or Hospitalizations: If none, please check here: ()

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Medications: (Please list all the medicines or vitamins you are currently taking)

_____ For What Condition? _____
_____ For What Condition? _____
_____ For What Condition? _____
_____ For What Condition? _____
_____ For What Condition? _____
_____ For What Condition? _____
_____ For What Condition? _____

Medication Allergies _____

Are there any other conditions or symptoms that may be related to your major problem? Yes No If yes, please explain _____

Any other diseases, major illnesses, or injuries not indicated on this form either in the past or the present. Yes No If yes, please explain _____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Chiropractor

Other _____

Personal Physician _____

May we send a report to your personal physician? Yes No

Specialists You Have Seen and Dates _____

For women only:

Date of last exam _____

Are you pregnant? Yes No Unsure

Nursing? Yes No Taking birth control? Yes No

Vaginal Bleeding? Yes No Circle: Normal or Abnormal

Vaginal Discharge? Yes No Color _____

Missed or Abnormal Periods? Yes No

