Reason for your visit

Patient _____ Date _____

Reason for today's visit_____

_____

Onset: Acute Chronic Gradual **When did your condition/accident occur?** ____/____/____

How did the injury occur? Accident _____Injury _____Physical Activity_____ Other _____

Has this or something similar happened in the past?_____

Side Right Left Both **Is your condition getting worse?** Yes No

How would you describe your discomfort? Circle all that apply.

Achy Burning Dull Sharp Stiff Throbbing Pressure Muscle Soreness Muscle Tension

Rate your discomfort on a scale of (0=no pain 10=severe) 0 to 10 _____

Is your discomfort Constant Frequent Intermittent Occasional

Does the pain radiate? Where?_____ Do you have Numbness? Where?_____

Weakness? Where? _____

What makes it worse? _____ What makes it feels better?_____

Does your condition interfere with your: Work Sleep Daily routine Recreation

What is your condition preventing you from doing? _____

Please list any surgeries with dates_____

Are you taking any of the following medications? Nerve pills Pain Killers (including aspirin) Muscle relaxers

Insulin Blood Thinners Tranquilizers Other _____

Do you take Supplements/Vitamins Yes No **Multi Vitamin?** Yes No **Fish Oil**? Yes No

Vitamin D? Yes No Units_____ **Do you exercise?** Yes No _____hours per week

Do you smoke? Yes No **How Much**?_____ **How Long**?_____ A**re you dieting** Yes No Since: ____/____/____

Are you pregnant? Yes No If yes, how many weeks?_____

Family Health History

TB / Cancer / Mental Illness / Diabetes / Asthma / Heart Disease / Stroke / Kidney Disease / Lung Disease / Arthritis

Other _____

Do you have a family history of Alzheimer's, Dementia or Mental decline? Yes No _____

About you

Patient Name: _____ Birthdate: ____/____/____ Male ____ Female _____

Age _____ SS# _____ Mailing Address: _____

City _____ State_____ Zip_____

Home Phone (____) _____ Work (____) _____ Cell (____)_____

Email address: _____@_____

Referred By: _____ Employer: _____Occupation:_____

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Do you have Children? Yes No How many? _____

In case of emergency contact? _____Relation: _____ Phone:_(____)_____

Insurance Info

Insurance Company _____ Insured's Name _____

Insured's ID# _____ Group#_____

Relationship to you _____ Insured's DOB ____/____/____

_____(Initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection fees, interest charges and any other expenses incurred in collecting the account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____(Initial) I acknowledge that I have received a copy of the Summary of Privacy Notice.

Signature _____ Date _____

Do you have OR have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / stroke	**Y N** Heart Surg. Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Artificial Valves	Y **N** Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe Frequent Headaches
Y N Ulcers / Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/Asthma
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints
Y N Mitral Valve Prolapse	**Y N** HIV+/AIDS/ ARC	**Y N** Anemia / Diabetes	**Y N** Kidney Problems
Y N Tuberculosis	**Y N** Arthritis		