PATIENT INFORMATION

NAME: ______________________________ DATE: ______________

D.O.B. ______________ AGE: ________ SEX: (CIRCLE) M F SS# ______________________

MARITAL STATUS (CIRCLE) S M D W WHAT DO YOU PREFER TO BE CALLED? ____________

HOME ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP: __________

HOME PHONE: __________________ WORK PHONE: __________________

CELL PHONE/PAGER: ________________ E-MAIL: ____________________

EMPLOYED BY: __________________ OCCUPATION: __________________

EMPLOYERS ADDRESS: ______________________________________

CITY: __________________ STATE: ______________ ZIP: ______________

INSURANCE NAME: __________________ POLICY# __________________

REASON FOR TODAYS VISIT (CHIEF COMPLAINT): __________________________

>>

HAVE ANY OTHER DOCTORS SEEN YOU FOR YOUR CURRENT CONDITION? (CIRCLE) YES NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING FOR ANY REASON? (CIRCLE)

ACUPUNCTURE PHYSICAL THERAPY MASSAGE CHIROPRACTIC CARE

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? ___ ANTI-DEPRESANTS
___ BLOOD THINNERS ___ TRANQUALIZERS ___ INSULIN ___ ASPIRIN/TYLENOL/ETC.
___ MUSCLE RELAXANTS ___ ANTI INFLAMMATORIES ___ PAIN KILLERS ___ OTHERS

>>

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

___ HEART ATTACKS/STROKE
___ HIV/AIDS
___ HIGH/LOW BLOOD PRESSURE
___ SEVERE FREQUENT HEADACHES
___ FAINTING/SEIZURES/EPILEPSY
___ ASTHMA
___ ARTIFICIAL BONES/JOINTS
___ ALCOHOL/DRUG ABUSE
___ CANCER
___ PSYCHIATRIC PROBLEMS
___ SINUS PROBLEMS
___ CHEMOTHERAPY
___ DIABETES
___ HEPATITIS
___ FREQUENT NECK PAIN
___ KIDNEY PROBLEMS
___ LOWER BACK PAIN
___ ARTHRITIS
___ DIFFICULTY BREATHING

PLEASE LIST **ANY** SERIOUS MEDICAL CONDITIONS YOU HAVE OR HAD: ________________
____

PLEASE LIST **ANY** SURGERIES (even if unrelated) AND APPROXIMATE AGES: ____________
____

LIST **ANY** PAST ACCIDENTS (even if not injured) WITH DATES: ____________________
____