

PATIENT INFORMATION

Name _____ Social Security # _____
 Last First Middle

Birthdate _____ Age _____ Male Female Single Married Separated Divorced

Mailing Address _____
 Street City State Zip

Home Phone _____ Cell Phone _____

Email address _____ Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Spouse/Parent Name _____ Work Phone _____

Spouse/Parent Employer _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

Reason for this visit: Illness Injury Job related injury Auto accident Other _____

Date of injury or onset of problem _____ Part of body injured _____ Right Left Both

How did this happen? _____

Worker's Compensation carrier _____ Claim # _____

Address _____ Claim Mgr Name & Number _____

If you were hospitalized for this: Where _____ When _____

PRIMARY Ins _____ SS# _____ Group # _____

Subscriber _____ Subscriber's Date of Birth _____ Relationship to subscriber
 self spouse child

Employer _____ Address _____ Work Phone _____

SECONDARY Ins _____ SS# _____ Group # _____

Subscriber _____ Subscriber's Date of Birth _____ Relationship to subscriber
 self spouse child

Employer _____ Address _____ Work Phone _____

In case of EMERGENCY: Relative to contact (other than spouse) _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: **If the patient is under 18 years of age, the accompanying parent is responsible for all bills.**

Signature _____ Date _____

Health History

This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Patient Name: _____ Birthdate _____ Date _____

What condition/body part(s) are you being seen for today? _____

Onset date: _____ Previous treatment for this condition? Yes No

Treatment given: _____ Date treated: _____

Where treated: _____

Check all treatment(s) received for this condition:

- | | | |
|----------------------|-----------|-------------------------------|
| Anti-inflammatories | X-rays | Hospitalization |
| Pain medication | MRI | Casting/splint |
| Muscle relaxant | CT scan | Physical therapy |
| Injection | Bone scan | Fracture to put back in place |
| Surgery & Date _____ | EMG | |

Allergies None Height _____ Weight _____

List all known allergies:

Current Medications None See attached list

List all known medications and dosage:

Past Medical History

Have you ever had:	No	Yes	Year
Anemia			
Angina			
Arthritis			
Asthma			
Bad teeth			
Bladder infection			
Bladder problems			
Blood clots			
Cancer			
Depression			
Diabetes			
Emphysema			
Epilepsy			

Have you ever had:	No	Yes	Year
Glaucoma			
Gout			
Heart attack			
Heart arrhythmia			
Hepatitis			
High blood pressure			
Kidney disease			
Liver disease			
Psychiatric treatment			
Stomach ulcers			
Stroke			
Thyroid disorders			
Tuberculosis			

Social History

Please answer each of the following:

Occupation: _____

How many years? _____

	No	Yes	How Much
Caffeine:			
Drugs:			

	No	Yes	How Much
Tobacco:			
Alcohol:			

Family History

Is there a family history of arthritis, heart disease, stroke or cancer? No Unknown Yes
(explain below)

Condition and relative: _____

Previous Surgeries

None List procedure and date performed:

Review of Systems

Check all conditions and symptoms that you currently have:

- | | | | | |
|--------------------|--|---|---|--------------------------------------|
| 1 General | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| 2 Eyes | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Glasses |
| 3 Ears/nose/throat | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sore throat |
| 4 Heart | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other |
| 5 Lungs | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other |
| 6 Intestinal | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| 7 Urinary | <input type="checkbox"/> Burning | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Other |
| 8 Musculoskeletal | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Other |
| 9 Skin | <input type="checkbox"/> Rashes | <input type="checkbox"/> Sores | <input type="checkbox"/> Masses | <input type="checkbox"/> Scars |
| 10 Neurological | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numbness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Dizziness |
| 11 Psychiatric | <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other |
| 12 Endocrine | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other |
| 13 Blood/Lymphatic | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Other |
| 14 OB/GYN | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Menopausal |

Provider Comments

_____ All other systems negative

Patient Signature: _____

Provider Signature: _____

Date: _____

Date: _____

Authorization to Leave Personal Health Information By Alternate Means

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

(Please check all that apply)

May leave detailed message on voicemail at home # : _____

May leave detailed message on voicemail at work # : _____

May leave information with spouse (name) : _____

May leave information with other family member: _____

May leave detailed message on cellular phone # : _____

May leave detailed message at a different location # : _____

May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature

Date

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record