PLEASE COMPLETE THIS FORM AS ACCURATELY AS POSSIBLE

E-MAIL ADDRESS:_____DATE:_____
NAME:_____AGE:_____BIRTH DATE:_____SS#:_____
ADDRESS:_____ CITY/STATE/ZIP_____SEX:___M___F
HOME#:_____CELL#:_____SPOUSES NAME:_____
FAMILY PHYSICIAN:_____ARE YOU RIGHT OR LEFT HANDED?_____R_____L
EMERGENCY CONTACT # (*NAME & # OF CONTACT*) _____
REASON FOR TODAY'S VISIT_____
DATE OF ACCIDENT IF APPLICABLE_____ BRIEFLY DESCRIBE ACCIDENT_____
PART OF BODY AFFECTED_____RATE YOUR PAIN 0-10 (IF APPLICABLE) 0=NONE 10=GREATEST_____
ARE YOU HAVING PAIN? YES OR NO IF YES, PLEASE ***CIRCLE*** ALL THAT APPLY:

Sharp	Stabbing	Acute Chronic	Worsening	Nighttime
Dull	Constant	Stable	Tingling	All the time
Throbbing	Intermittent	Improving	Daytime	

DOES YOUR PAIN (IF APPLICABLE) INCREASE WITH ACTIVITY? EXPLAIN_____

WHAT HAVE YOU TRIED TO EASE YOUR SYMPTOMS? SPLINTS, ICE, SOAKS, MEDS_____

ANSWER YES OR NO TO THE FOLLOWING, IF ANSWERED YES, ***PLEASE CIRCLE AND EXPLAIN***.

HEIGHT_____
WEIGHT_____

YES	**NO**	
☐	☐	**CONSTITUTIONAL** (Fever, Weight loss, Night sweats)_____
☐	☐	**CARDIOVASCULAR** (Heart attack, Stroke, Chest pain, Valve disease, Stents)_____
☐	☐	**RESPIRATORY** (Emphysema, Asthma, Tuberculosis, Positive TB test, Environmental allergies)_____
☐	☐	**ENDOCRINE** (Diabetes, Thyroid)_____
☐	☐	**MUSCULOSKELETAL** (Previous fracture, Arthritis, M.D.,)_____
☐	☐	**INTEGUMENTARY** (Psoriasis, Eczema)_____
☐	☐	**PSYCHIATRIC** (Depression, Anxiety, Stress, ADD/ADHD)_____
☐	☐	**HEMATOLOGIC** (Anemia, Bleeding tendency, Circulatory problems, Raynauds)_____
☐	☐	**GENITAL/URINARY** (Infection, Kidney stones, Prostate, Dialysis)_____
☐	☐	**GASTROINTESTINAL** (Ulcer, Gastritis, Colitis, Acid Reflux, Heart burn, IBS)_____
☐	☐	**NEUROLOGICAL** (Seizures, Numbness, Tremors, Migraines)_____
☐	☐	**AUTOIMMUNE** (Fibromyalgia, M.S., Hepatitis, H.I.V)_____
☐	☐	**OTHER PROBLEMS** (High Cholesterol or Blood Pressure, Cancer (Location)_____

Dr. Initials & Date_____ Dr. Initials & Date_____ Dr. Initials & Date_____

CONTINUED ON REVERSE SIDE

WHEN WAS YOUR LAST TETANUS INJECTION?_____
DO YOU HAVE SLEEP APNEA?_____HAVE YOU HAD A SLEEP STUDY?_____
DO YOU USE A CPAP?_____DO YOU SNORE EXCESSIVELY?_____
SURGERY/HOSPITALIZATION HISTORY (List **all** surgeries and in-patient hospitalization)

_____
_____
_____

ALLERGY/SENSITIVITY to medication/latex/tape/food,etc._____
_____
_____

CURRENT MEDICATIONS (Also include non-prescription medication, herbs, and dietary supplements taken.)

Medication	Dose	Daily Amount	Medication	Dose	Daily Amount	Medication	Dose	Daily Amount
1._____			5._____			9._____		
2._____			6._____			10._____		
3._____			7._____			11._____		
4._____			8._____			12._____		

FAMILY HISTORY (Besides yourself, please answer yes or no to the following family illnesses. If yes, please identify the person by their relationship to you.)

YES	**NO**	
☐	☐	**LUNG DISEASE** (Asthma, Emphysema, T.B)_____
☐	☐	**HEART DISEASE** (Congestive Ht. Failure, Ht. Attack, Open Ht Surgery)_____
☐	☐	**HIGH BLOOD PRESSURE/STROKE**_____
☐	☐	**DIABETES**_____
☐	☐	**CANCER**_____
☐	☐	**ARTHRITIS**_____
☐	☐	**OTHER**_____

SOCIAL HISTORY
Marital Status (Please Circle) S M W D How many children do you have?_____
Current Employer_____ Job Description_____
Number of years worked for this employer_____ Occupational history_____
Do you smoke cigarettes?_____ If yes, how many packs per day?_____ How many years?_____
Do you drink alcohol?_____ If yes, how many drinks per week?_____ Drinks per day?_____
Do you have a current or past history of substance abuse?_____ If yes, please explain_____ _____

RESPONSIBLE PARTY INFORMATION

If patient is a minor, who is financially responsible?_____
Their social security number_____ Work phone_____
If patient is a minor, please list person bringing this child today_____
Relationship to patient (Circle One) MOTHER FATHER STEPMOTHER STEPFATHER LEGAL GUARDIAN OTHER_____

_____ _____ _____
(**Patient Signature)** (**Date**) (**Parent/Guardian Signature**)