

Today's date: ___/___/_____

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____

DOB: ___/___/_____

Gender: Female Male

Address: _____

City, State, Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email Address: _____

Emergency contact name: (Last) _____ (First) _____

Phone: _____ Relationship to patient: _____

Primary Care Provider: _____ Phone: _____

Address: _____

Pharmacy Name: _____ Phone: _____

Address _____

How did you hear about us? Check all that apply:

Family or Friend Former or Current patient Internet Search Physician/Provider - Website -Other

Please Specify _____

Reason for Visit: _____

When did symptoms begin: _____

Is this a result of an injury? No Yes

If yes, check one: Work-related Auto Accident Sports Injury Other accident

Date of Injury: _____ Is there litigation pending: No Yes

Describe how accident occurred: _____

Is your condition affecting your activities of daily living? No Yes

Mark your current level of pain: 😊 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ 😞

Do you use any of the following? Check all that apply: Cigarettes Cigars Pipe Smokeless-Tobacco Vape

If yes how many per day? _____ Have you ever smoked? No Yes If yes, when did you quit? _____

Do you use alcohol? No Yes If yes, how many drinks per week? _____

Are you allergic to latex: No Yes

Are you allergic to any jewelry or metal (if yes please explain): _____

List allergies to medications: _____

Current medications/supplements	Dosage

Previous Surgery	Date

Have you ever had a surgical complication? Yes No

Please Specify: _____

Have you ever had any of the following? Check all the apply: Joint Disease Stroke Thyroid Blood Clot
 High Blood Pressure Tuberculosis Diabetes Cancer Heart Disease

Other: _____

Do any of these conditions run in your family? Check all that Apply:

Family member	Diabetes	Lung Cancer	Breast Cancer	Heart Disease	Joint Disease	Stroke	Blood Clot	Psychiatric Disorder
Father								
Mother								
Sister								
Brother								
Other								

If there is anything else we should know or you did not have room to finish feel free to continue on the back of this form.

Signature: _____