Today's date: ____/____/_____

PATIENT INFORMATION

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

DOB: _____/_____/_____ Gender: ☐ Female ☐ Male Occupation: _____

Address:_____

City, State, Zip:_____

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

Email Address: _____

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

Phone: _____ Relationship to patient: _____

Primary Care Provider: _____ Phone: _____

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

Height: _____ Weight: _____ 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								

Signature: _____

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