Patient Name: ______________________________
Date of Birth: ________________

Patient Information Form

Date: ________________
Patient Name: ________________ _____________ ___ Birth: _________ Age: ____ Sex: M F
Last First MI

Home Address: ________________________________ City/State:__________________ Zip: ______

May We Leave a Message?
Home Phone #: (______) _____-__________ Yes No
Work Phone #: (______) _____-__________ Yes No
Cell Phone #: (______) _____-__________ Yes No
E-mail: _______________________________ Yes No

Primary Language: ________________________
Do you have a Legal Guardian or Healthcare Power of Attorney? Yes No
If yes, Name: __________________ Relationship: _________ Phone#: (_____) ____-_________

Emergency Contact:___________________ Relationship: _________ Phone#: (_____) ____-_________

Primary Care Doctor: _________________ Who referred you to us? ____________________________

Is there a family member or other person you would like for us to share your clinical information?
___ Yes Name(s) ____
___ No

Who is responsible for payment? ___________________ Relationship to Patient? ____________________
Address: ______________________ City/State: ______________ Zip: _________ Phone#: ___________

Insurance Information

Are you eligible for Medicare and/or Medicaid? _______________

Primary Insurance Company Name: ____
Address: _____________________ City/State: ______________ Zip: _________ Phone #: ___________
Member ID: ______________________________ Group#: _____________________

Secondary Insurance Company Name:
____
Address: _____________________ City/State: ______________ Zip: _________ Phone#: ___________
Member ID: ______________________________ Group #: _____________________

Patient Name: ______________________________
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Your Medical History

Allergies: ☐ None Known ☐ Medications ____
☐ Anesthesia________________________ ☐ Foods____________________________________
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other ____________________________________

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arithritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV + / AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Emphysema	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Other Conditions					

Please check all of the following that apply to you:

☐ Recent Fever
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Prostate Problems
☐ Menstrual Problems
☐ Currently Pregnant
☐ Abnormal Weight Gain/Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position
☐ Pain That Wakes You

Please list all **medications** you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name Dose How often do you take?

____
____
____
____

Please list all prior surgeries:

Type of Surgery Date Type of Surgery Date

____________________________________ ______________________________________
____________________________________ ______________________________________

Please list all prior Hospitalizations (other than for surgery):

Reason for Hospitalization Date Reason for Hospitalization Date

____________________________________ ______________________________________
____________________________________ ______________________________________

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Social History

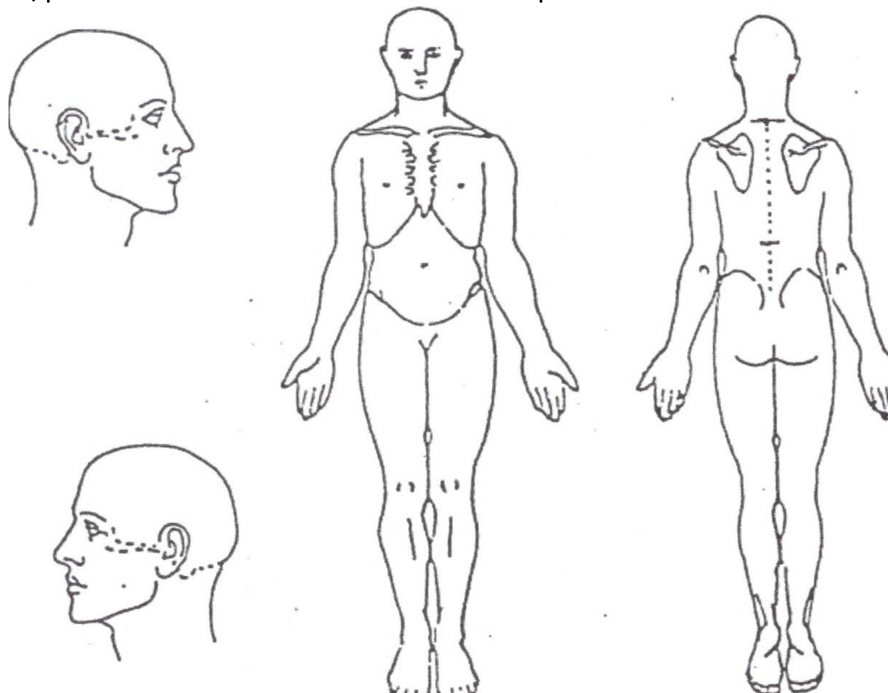
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐Widowed
Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse ____________________
☐ Current Use – Type ____________________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Use of Tobacco: ☐ Never ☐ Quit – How long ago? _______ ☐ Smoke ___ packs/day for ___ years
Use of Recreational Drugs: Is there any use which could possibly affect your health? ____________
Employer: ______________________________ Occupation: _________________________________
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐75% ☐100%
Do others depend on you for their care? ☐ Children – age(s) _________________________________
☐ Pet(s)-What Kind ? _________________ ☐ Elderly or Disabled Family Member
☐ Other ____
Exercise: ☐ Never ☐Rare ☐ Monthly ☐ Weekly ☐ Several times per Week ☐ Daily
Types of Exercise: ____

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other ____

Current Problem

What specific problem brings you to our office today? ______________________________________
Have you had this condition in the past? ________ If yes, when? ____________________________
Where is the pain/problem located? Please mark on the pictures below.



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How long ago did this problem start? _______ Days / Weeks / Months / Years
Did your pain or problem: ☐ Begin all of the sudden ☐ Gradually developed over time
How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Throbbing ☐ Other ___________________________

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time your pain began, has it: ☐ Stayed the Same ☐ Become Worse ☐ Improved

Please indicate what activities aggravate or make your condition worse:
☐ Sitting ☐ Standing ☐ Coughing ☐ Sneezing ☐ Kneeling ☐ Bowel Movement
☐ Lying ☐ Twisting ☐ Bending ☐ Lifting ☐ Stooping ☐ Other _____________
☐ Pushing ☐ Pulling ☐ Walking ☐ Climbing ☐ Gripping

What makes your pain/condition feel better?
☐ Lying ☐ Sitting ☐ Walking ☐ Nothing
☐ Hot Packs ☐ Standing ☐ Rest ☐ Other ____
☐ Cold Packs ☐ Medications ____

What treatments have you had for this problem? ____

Has the problem affected your lifestyle or ability to work? ☐ Work ☐ Taking a Shower/Bath
☐ Washing Your Hair ☐ Gardening ☐ Recreational Activities (sports) ☐ Grocery shopping
☐ Marital Relations ☐ Cleaning House ☐ Sleeping

Was this problem caused by an injury? ☐ No ☐ Yes (Describe) _______________________________
If yes, was it a work related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changers in my medical status.

_______________________________________ _______________________________________
Print Name of Patient, Parent or Guardian Signature of Doctor and Date Reviewed

_______________________________________ _______________________________________
If Other Than Patient, Relationship to Patient Date

____
Signature