Rev. 1/13

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address				Work Phone #		

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES_____NO_____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

PLEASE PROVIDE INFORMATION WHICH HELP COMPLETE YOUR HEALTH RECORD

Name: _____ Date: ____/____/____

DOB ____/____/____ Height: ____' ____" Weight: ____lbs Handed: R L

LIST ALL MEDICATIONS AND DOSAGES:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICATION ALLERGIES: _____

MEDICAL INFORMATION: (Please check all boxes that apply.)

- ❑ DIABETES ____ years
- ❑ HIGH BLOOD PRESSURE
- ❑ HIGH CHOLESTEROL
- ❑ HEAVY METAL EXPOSURE
- ❑ SEIZURES
- ❑ STROKE
- ❑ B12 DEFICIENCY
- ❑ LUNG DISEASE/COPD
- ❑ THYROID PROBLEMS
- ❑ TB (Tuberculosis)
- ❑ KIDNEY
- ❑ HEART ARRYTHMIA
- ❑ HEART ATTACK
- ❑ OTHER HEART PROBLEMS
- ❑ CANCER Type _____ ❑ Radiation Treatments ❑ Chemotherapy
- ❑ HEAD TRAUMA When _____ ❑ Car Accident ❑ Other
- ❑ SURGERY TYPE WHEN
  - ❑ NONE _____ _____
  - _____ _____
- ❑ STOMACH/BOWEL DISORDER/ULCERS
- ❑ EXERCISE HOW OFTEN _____
- ❑ SMOKE HOW OFTEN _____
- ❑ DRINK ALCOHOL AMOUNT _____ HOW OFTEN _____

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING PROBLEMS? (Please check all boxes that apply.)

- ❑ Dizziness
- ❑ Sleep Problems
- ❑ Fever/Chills
- ❑ Burning Feet
- ❑ Bone/Joint Problems
- ❑ Immune System Problems
- ❑ Depression
- ❑ Blood or Lymphatic Problems
- ❑ Visual Problems
- ❑ Passing Out
- ❑ Headaches
- ❑ Tremor
- ❑ Rash/Skin Problems
- ❑ Unexplained Weight Gain/Loss
- ❑ Muscle/Tendon Problems
- ❑ Nose/Throat/Mouth Problems
- ❑ Shortness of Breath/Lung Problems
- ❑ Kidney/Bladder Problems
- ❑ Decreased Hearing
- ❑ Bowel/Stomach Problems
- ❑ Unexplained Sweats/Night Sweats
- ❑ Numbness/Tingling in Arms/Legs
- ❑ Chest Pain/Heart Problems
- ❑ Emotional Stress

FAMILY MEDICAL HISTORY

Father _____
Mother _____
Siblings _____
Grandparents _____

PHYSICIAN: _____