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Patient Information Form

(Please print)

Date: __/__/____

Patient Name: _____ Date of Birth: __/__/____

(Last) (First) (M.I.)

Age:___ Sex: ▢ Male ▢ Female Race:_____ Ethnicity:_____

Home Address: _____ City/State:_____

Zip: _____ Email Address: _____

SSN: ___-___-____

How May We Contact You?

	May we Leave a Message?	Text?
Home Phone #: (___) ___-____	▢	▢
Work Phone #: (___) ___-____	▢	▢
Cell Phone # : (___) ___-____	▢	▢
Email: _____	▢	▢

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: _____ Phone #: (___) ___-____

Pharmacy:_____ Location:_____ Phone #: (___) ___-____

Is there a family member or other person you would like for us to share your medical information?

▢ Yes Name(s): _____

▢ No

Who is responsible for payment?

▢ Self

▢ Other

Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____

Zip: _____ Phone #: (___) ___-____

Insurance Information

Primary Insurance Company: _____

Address: _____ City/State/P.O Box: _____

Zip: _____ Phone #: (___) ___-____

Insured Name: _____ Date Of Birth: __/__/____

Policy#: _____ Group #: _____

Secondary Insurance Company: _____

Address: _____ City/State/P.O Box: _____

Zip: _____ Phone #: (___) ___-____

Insured Name: _____ Date Of Birth: __/__/____

Policy#: _____ Group #: _____

How did you hear about us?

▢ Referred by a Physician

Physician name: _____

▢ Referred by a friend

Name of friend: _____ Relationship: _____

▢ Contacted your insurance

Insurance company: _____

▢ Found us online

▢ Our website ▢ Google Reviews ▢ Other Source

Other source: _____

▢ Found us through social media

▢ Facebook ▢ Twitter ▢ LinkedIn

▢ Other (Please describe)

_____

Social History

Marital Status: ▢ Single ▢ Married ▢ Seperated ▢ Divorced ▢ Widowed

Use of Alcohol: ▢ Never ▢ No Longer Use- How Long Ago

▢ Currently Use- ▢Rare ▢Occasional ▢Moderate ▢Moderate ▢Weekly ▢Daily

Use of Tobacco: ▢ Never ▢ No Longer Use- How Long Ago_____

▢ Currently Use- ▢Rare ▢Occasional ▢Moderate ▢Moderate ▢Weekly ▢Daily

Drug Use: ▢ Never ▢ No Longer Use- How Long Ago_____

▢ Currently Use- ▢Rare ▢Occasional ▢Moderate ▢Moderate ▢Weekly ▢Daily

Type of Drug: _____

Employer: _____ Occupation: _____

How much are you on your feet at work? ▢ 10% ▢ 25% ▢ 50% ▢ 75% ▢ 100%

Do others depend upon you for their care? ▢ Children-Age(s)_____

Pet(s)-What kind?_____ ▢ Elderly or Disabled family member ▢

Other_____

Exercise: ▢ Never ▢ Rare ▢ Occasional ▢ Weekly ▢ Several Times A Week ▢ Daily

Type(s) of exercise: _____

Medical History

Allergies: ▢ Medications: _____

▢ Anesthesia: _____ ▢ Foods: _____

▢ Tape ▢ Latex ▢ Shellfish ▢ Iodine ▢ Other_____

▢ No Known

Family History: Do you have a family history of : ▢ Diabetes: Type 1 or Type 2 ▢ Cancer

▢ Heart Disease ▢ High Blood Pressure ▢ Stroke ▢ Coronary Artery Disease

▢ Thyroid Disease ▢ Rheumatoid Arthritis ▢ Other_____

Have you ever had any of the following?

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
ARTHRITIS	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/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

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:

_____ _____

_____ _____

_____ _____

Current Medications and Prescriptions

RX _____ Dosage: _____ RX _____ Dosage:_____

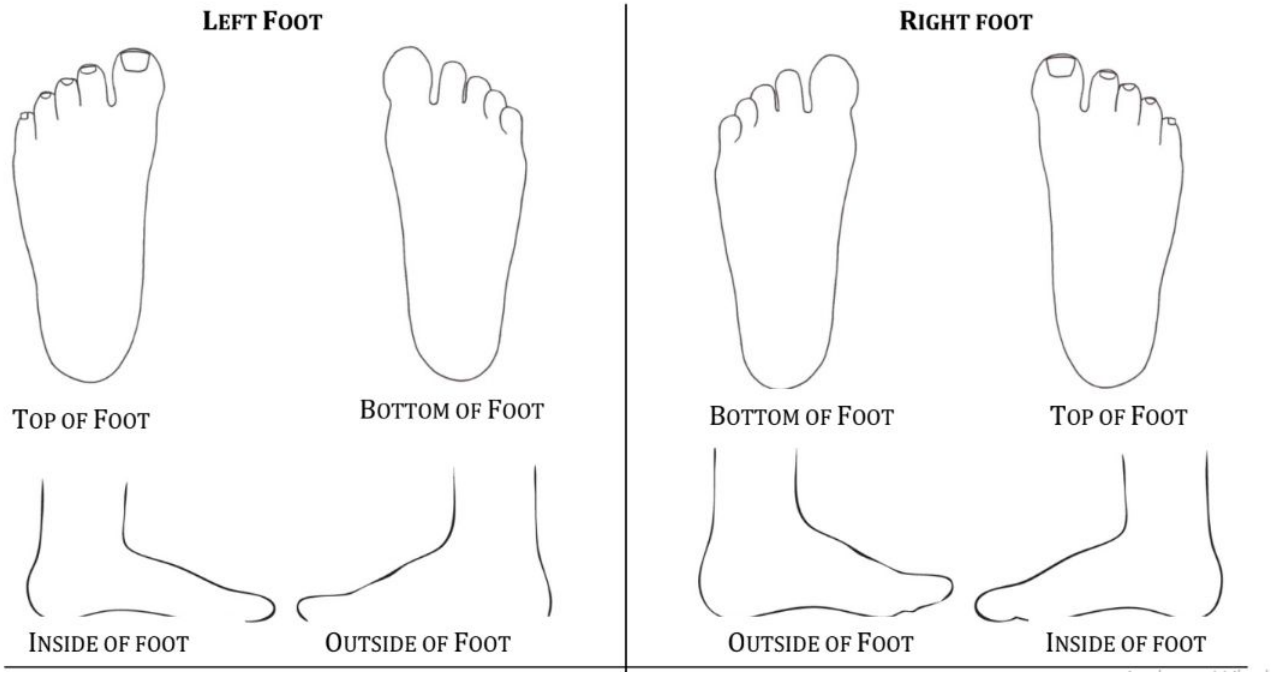
RX _____ Dosage: _____ RX _____ Dosage:_____

RX _____ Dosage: _____ RX _____ Dosage:_____

Current Problem

What specific problem(s) brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below:



How long ago did this problem first start? _____ Days/ Weeks/ Months/ Years

Did your pain or problem: ▢ Begin all of a sudden ▢ Gradually develop over time

How would you describe your pain? ▢ No pain ▢ Sharp ▢ Dull ▢ Aching ▢ Burning

▢ Radiating ▢ Itching ▢ Stabbing ▢ Other_____

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

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

What makes your pain or problem feel worse? ▢ Walking ▢ Standing ▢ Daily activities

▢ Resting ▢ Dress shoes ▢ High heels ▢ Flat shoes ▢ Any closed toe shoe

▢ Running ▢ Other_____

What treatments have you had for this problem? _____

Was this problem caused by an injury? ▢ Yes (Describe) _____

▢ No

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 changes in my medical status.

_____	_____
Print Name of Patient, Parent or Guardian	Signature of Doctor
_____	_____
If other than Patient, Relationship to Patient	Date
_____	_____
Signature	**Date**