



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 Separated 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: |
|----------------------------|-------|----------------------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

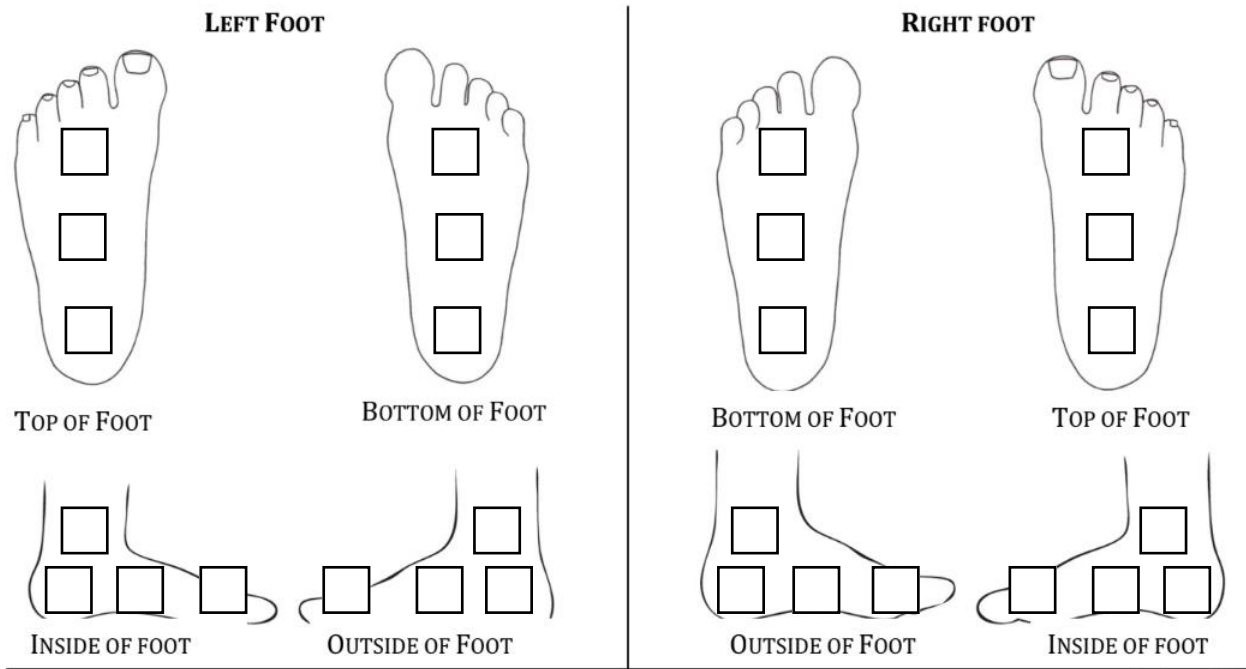
Current Medications and Prescriptions

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

If other than Patient, Relationship to Patient

Signature

Signature of Doctor

Date

Date