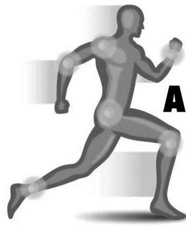

Today's Date: ______________________________ **Email:** ________________________

Name: ____
(Last) (First) (MI) (Nick Name)

Marital Status: ______________________ **Sex: M F Date of Birth:**___/___/__ **SS#**___/__/____

Address: ____
Street Number or P.O. Box City State Zip

Home Phone: ( ) __________-_______ **Work: ( )** _________-________ **Cell: ( )** _______-_________

Emergency Contact: ____ ( ) _____-________
Name and Relationship of person outside Immediate Home Phone Number

Name of Spouse: ____________________________________**Spouse Employer:** ______________

Patients Employer: ____

School:____**Sport:**_________________________

How did you hear about us?____

Reason for visit? ____
Date of Injury/Accident Occurred: ______/______/_______
How did injury occur: ____
Drug Allergies: ____

Primary Insurance: ___________________________**Secondary Insurance:** ___________________

Policy Holders Name:__________________________**Policy Holders Name:** ___________________

Relationship to Patient:________________________**Relationship to Patient:**__________________

DOB:____/____/____ **SS#** ___/___/______ **DOB:**____/____/____ **SS#:**___/___/______

Contract # _____________________ **Grp#**_______ **Contract #** ______________ **Grp#**_________

Policy Holders Employer:________________________ **Policy Holders Employer:**_______________

Is this a WORKMAN COMPENSATION CASE? Yes___ No___ If yes, please provide the following:

Date Of Injury: _____/_____/_____ **Employer:**______________________________

Work Comp Carrier: ____________________________ **Address:** ______________________________

List any Coach, Trainer, or Doctor and Complete Address that you want to receive a report.

Doctor:____

Coach/Trainer: ____

Pharmacy:_________________________________ **Phone:**___________________

Address:____

Current Medications: Please list *ALL* medications.

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			4.		
2.			5.		
3.			6.		

Please list hospital admissions:

Type of Surgery/Illness	Year	Type of Surgery/Illness	Year
1.		3.	
2.		4.	

Family Medical History: Please check medical illness affecting your immediate family, e.g., parents and sibling.

___ Cancer
___ Diabetes Type 1 or 2
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Stroke

Social History: Check appropriate line and fill in blanks.

Married ___ Single ___ Divorced ___ Widowed ___ Other ___ Alcohol ___

Alcohol: Occasional ___ Daily ___ Heavy ___ No consumption ___

Tobacco: Yes ___ No___ Years Used ___ Packs Per Day ___ Drugs ___

General History: Please check if any apply.

GENERAL

__Weight Change
__Fever or Chills
__Night Sweats
__Urinary Frequency
__Bleeding
__Lumps or Masses
__Dizziness or Fainting
__Itching or Rash
__Diabetes Mellitus
__Thyroid Problems
__Cancer

CARDIOVASCULAR

__Heart DX/Pain
__Hypertension
__Mitral Valve Prolapse
__Thrombophlebitis

RESPIRATORY

__Cough/Sputum
__Rheumatic Fever
__Tuberculosis
__Pleurisy Pneumonia
__Asthma

MUSCULOSKELEAL

__Backache
__ Joint Pain
__Joint Swelling

BREAST

__Lumps
__Pain
__Discharge

EAR-EYES-NOSE-THROAT

__Visual Change
__Hearing Change
__Tinnitus
__Dentures
__Bleeding Gums
__Hoarseness

GENITOURINARY

__Urinary Infections
__Incontinence
__Veneral Disease
__Menopause

NEUROLOGIC

__Seizures
__Paralysis
__Numbness
__Weakness

GASTROINTESTINAL

__Dysphasia (Difficulty in swallowing) __Nausea & Vomiting __Jaundice __Hepatitis