NAME_____
LAST FIRST MIDDLE

BIRTH DATE_____ AGE_____SEX_____

MAILING
ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____CELL PHONE_____

SOCIAL SECURITY #_____EMAIL_____

EMERGENCY
CONTACT_____
NAME PHONE RELATIONSHIP

PRIMARY CARE
PHYSICIAN_____
NAME/PRACTICE LAST SEEN

PREFERRED PHARMACY_____

Please see the receptionist with your insurance card(s) and a photo ID.

If the responsible party is different from the patient, please fill out the section below:

NAME _____ DOB_____

ADDRESS_____

PHONE_____RELATIONSHIP TO PATIENT_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary for the processing of insurance claims, insurance applications, and prescriptions. I do also authorize the payment of medical benefits to the physician who is rendering care.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____

DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and a copy of the Financial Policy. I have had the opportunity to read each of them if I so chose, and I understand the outlined practices and policies.

PATIENT NAME_____

DATE_____

SIGNATURE_____

PARENT OR AUTHORIZED PARTY SIGNATURE (IF APPLICABLE)

_____

HEALTH HISTORY AND PRESENT ILLNESS

NAME_____HEIGHT_____WEIGHT_____

SHOE SIZE_____

REASON FOR TODAY'S VISIT_____

DATE OF INJURY OR ONSET OF PROBLEM_____

CIRCLE ALL THAT APPLY:

THROBBING SHARP DULL BURNING ACHING PINS/ NEEDLES

SIDE AFFECTED: LEFT RIGHT BOTH

PAIN: MILD MODERATE SEVERE

DESCRIBE CONDITION: GETTING BETTER WORSE STAYING THE SAME

DO YOU HAVE: SWELLING NUMBNESS TINGLING BRUISING

DESCRIBE WHAT MAKES IT BETTER_____

DESCRIBE WHAT MAKES IT WORSE_____

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE LAST THREE MONTHS? PLEASE CIRCLE:

FEVER CHILLS NAUSEA VOMITING DIARRHEA HEADACHE DIZZINESS

FATIGUE DYSCOORDINATION CRAMPING COLD TOES RASHES ITCHING

DRY SKIN FATIGUE IN LEGS WHEN WALKING SHORTNESS OF BREATH NUMBNESS

TINGLING JOINT PAIN WEAKNESS CHEST PAIN JOINT STIFFNESS

DO YOU USE AN ASSISTIVE DEVICE? (BRACES, CANE, WHEELCHAIR, ETC)_____

WHAT KIND OF SHOES DO YOU NORMALLY WEAR?_____

Name_____

ALLERGIES_____

MEDICATION LIST (INCLUDE DOSE AND FREQUENCY, OVER THE COUNTER AND SUPPLEMENTS)

_____

_____

_____

_____

HAVE YOU RECEIVED ANY OF THE FOLLOWING DIAGNOSES? PLEASE CIRCLE:

DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	HEART ATTACK
STROKE	HIGH CHOLESTEROL	HEART FAILURE	CIRCULATORY PROBLEMS
COPD/EMPHYSEMA	THYROID	EPILEPSY	HIV+
ASTHMA	SPINE/NERVE PROBLEMS	MUSCLE WEAKNESS/ SPASTICITY	FIBROMYALGIA
OSTEOARTHRITIS	RHEUMATOID ARTHRITIS	GOUT	SLEEP APNEA
ANEMIA	ULCERS	ACID REFLUX	HEPATITIS B/C
BLADDER DYSFUNCTION	CANCER, TYPE_____	ANXIETY	DEPRESSION

ANY OTHER DIAGNOSES NOT LISTED_____

ARE YOU POSSIBLY PREGNANT? YES NO

DO YOU SMOKE? YES NO HOW MANY DAILY?_____HOW LONG?_____

DO YOU DRINK ALCOHOL? YES NO HOW MANY DRINKS A WEEK?_____

HISTORY OF PRESCRIPTION OR ILLICIT DRUG USE? YES NO TREATMENT? YES NO

ANY MEDICAL PROBLEMS RUN IN YOUR FAMILY? (SIBLINGS/PARENTS)_____

_____

SURGICAL HISTORY_____

_____