NEW PATIENT INFORMATION

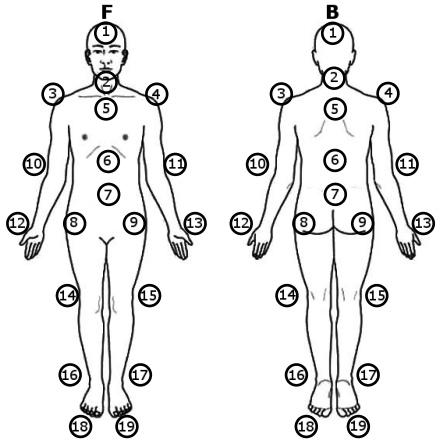
PERSONAL INFORMATION: TODAY'S DATE:

NAME: _____ DOB: ____/____/_____ SS#: _____-____-_____ SEX: M F
STREET: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (_____)_____-_____ CELL PHONE: (_____)_____-_____ OTHER: (_____)_____-_____
EMAIL ADDRESS: _____ MARITAL STATUS: S M D

EMPLOYER NAME: _____OCCUPATION: _____
EMPLOYER ADDRESS: _____ WORK PHONE: (_____)_____-_____
EMPLOYER CITY: _____ STATE: _____ ZIP: _____
EMERGENCY CONTACT: _____ PHONE: : (_____)_____-_____
PRIMARY CARE PHYSICIAN: _____ PHONE: (_____)_____-_____ MAY WE CONTACT: Y N

PRESENT COMPLAINT:
PLEASE BRIEFLY DESCRIBE YOUR SYMPTOM(S):

_____
_____
_____



Indicate the pain level you are currently experiencing and where on the picture provided.

<NO PAIN> 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 <DEATH>

☐ Shooting ☐ Aching ☐ Burning ☐ Stiffness
☐ Dull ☐ Sharp ☐ Throbbing ☐ Cramping
☐ Numbness ☐ Other _____

ARE THESE SYMPTOMS DUE TO AN ACCIDENT? Y N IF YES, TYPE OF ACCIDENT: ☐AUTO ☐WORK ☐OTHER
DATE OF ACCIDENT: ____/____/_____ ACCIDENT REPORTED: Y N ☐ Worker's Comp ☐Insurance ☐Employer
HAVE YOU RETAINED AN ATTORNEY FOR THIS ACCIDENT: Y N
IF YES, ATTORNEY'S NAME AND PHONE NUMBER: _____
(IF THIS IS WORKERS COMP) Worker's Comp #: _____
NAME OF INSURANCE OF THE AT FAULT PARTY: _____ CLAIM #: _____
NAME OF YOUR AUTO INSURANCE: _____ CLAIM #: _____
NAME OF YOUR HEALTH INSURANCE: _____ POLICY #: _____

MEDICAL HISTORY:
DO YOU OR ANY FAMILY MEMBERS HAVE HISTORY OF THE FOLLOWING?

☐ Anemia	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ High Blood Pressure	☐ Allergies	☐ Cancer
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Tuberculosis	☐ HIV	☐ Sinus Trouble
☐ Asthma	☐ German Measles	☐ Nervousness	☐ Heart Trouble	☐ Numbness	☐ Convulsions
☐ Epilepsy	☐ Concussion	☐ Dizziness	☐ Digestive Disorders	☐ Neuritis	☐ Rheumatism
☐ Diabetes	☐ Arthritis	☐ Venereal Disease	☐ Hepatitis	☐ Backaches	

Exercise Frequency: ☐ None ☐Seldom ☐Weekly ☐Daily Type: _____

HAVE YOU HAD ANY OPERATIONS OR SURGERIES? Y N IF YES, LIST THE DATE AND SURGERY(S) PERFORMED _____
_____
LIST THE DATE OF ANY PREVIOUS ACCIDENTS OR FALLS. ☐Auto ☐ Recreational ☐Work ☐ Other _____
LIST ANY BROKEN BONES/FRACTURES/DISLOCATIONS: _____
HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? Y N
ARE YOU PREGNANT OR THINK YOU ARE PREGNANT? Y N DATE OF LAST MENSTRUAL PERIOD: ____/____/_____
HAVE YOU BEEN TREATED BY A DOCTOR FOR A HEALTH CONDITION IN THE PAST YEAR? Y N
IF YES, DESCRIBE: _____
LIST ANY MEDICATION YOU ARE TAKING: _____

I ATTEST THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____/___/_____
SIGNATURE DATE