Date:

Patient Information

☐ **New Patient** ☐ **Returning Patient**

Last Name	First Name	Middle Initial

Date of Birth MM/DD/YYYY _____/_____/_____	Sex ☐ Male ☐ Female	Social Security #

Address	City	State	Zip Code

Primary Phone Number ☐ Home ☐ Work ☐ Cell	Secondary Phone Number ☐ Home ☐ Work ☐ Cell	Preferred Contact Method ☐ Phone call ☐ Text ☐ Email

Marital Status	Email	Employment Status
☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated ☐ Partner	To be used for provider communication, follow up, patient portal, and practice related material. We DO NOT share email information with other parties. You may choose to remove at any time.	☐ Full time ☐ Part time ☐ Not employed ☐ Student ☐ Homemaker ☐ Retired

Preferred Language ☐ English ☐ Spanish ☐ Other _____	Employer	Job Title

Race			Preferred Pharmacy:
☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander	☐ Other Race	
☐ Asian	☐ Black or African American	☐ Unreported	
☐ Hispanic	☐ White		

Insurance Information

Primary Insurance Company	
Name of Policy Holder ☐ Same as above	Policy Holder's Date of Birth ☐ Same as above ____/_____/_____
Policy Holder's Relationship to Patient ☐ Self ☐ Mother ☐ Father ☐ Other _____	Policy Holder's Social Security # ☐ Same as above
Subscriber Number	Group Number
Secondary Insurance Company ☐ N/A	Name of Policy Holder ☐ Same as above
Secondary Subscriber Number	Secondary Group Number

In Case of Emergency

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following listed individuals:			
Name	**Relationship**	**Phone Number**	**Yes or No**

Reason For Today's Visit

Chief Complaint (please describe symptoms)	Referred By

☐ Medical Treatment (list symptoms above)	☐ Physical - ☐ School ☐ Work ☐ DOT	Onset/Injury Date
☐ Work Related Injury – Worker's Compensation	☐ Pre-op Medical Clearance	
☐ Car Accident or Auto Related Injury	☐ Unknown Cause	
☐ Home Injury	☐ Other _____	

Name: Date:

Please report previous treatment received for condition

☐ Emergency Room	☐ Prescribed Medication	☐ Surgery	☐ Ice	☐ Other: _____
☐ Physical Therapy	☐ Over-the-counter Medication	☐ Rest	☐ Heat	☐ Other: _____
☐ Massage	☐ Chiropractic Adjustment	☐ Stretching	☐ Bracing	☐ Other: _____

Current Medications

Medication	Dosage	Condition

Medical History (check all that apply)

☐ ADD/ADHD	☐ Chronic Fatigue Syndrome	☐ Hearing Impairment	☐ Pacemaker
☐ AIDS/HIV	☐ Constipation	☐ Heart Disease	☐ Parkinson's Disease
☐ Allergies	☐ COPD	☐ Heart Murmur	☐ Pinched Nerve
☐ Alzheimer's/Dementia	☐ Depression	☐ Hepatitis	☐ Scoliosis
☐ Anemia	☐ Diabetes: Insulin / Non-insulin	☐ Herniated Disk	☐ Seizure Disorder
☐ Appendicitis	☐ Ear Infections	☐ Herpes/Lesions/Shingles	☐ Sinusitis
☐ Arthritis	☐ Eating Disorder	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Eczema	☐ High Cholesterol	☐ STD
☐ Autoimmune Condition	☐ Eye Problems	☐ Hypoglycemic	☐ Stroke/ TIA
☐ Back Pain	☐ Fainting /Syncope	☐ Influenza/ Pneumonia	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Joint Pain	☐ Tonsillitis
☐ Bronchitis	☐ Fractures	☐ Kidney Disease/ Stones	☐ Tumors/Growths
☐ Cancer: _____	☐ Gallbladder Disorder	☐ Measles/ Mumps/ Rubella	☐ Ulcers
☐ Cataracts	☐ Glaucoma	☐ Miscarriage	☐ Vaginal Infections
☐ Chest Pain	☐ Gout	☐ Mononucleosis	☐ Vertigo
☐ Chicken Pox	☐ Headaches	☐ Osteoporosis	☐ Other:

Allergies

Medication Allergies:	Reaction:
Supplement Allergies:	Reaction:
Food Allergies:	Reaction:
Other:	Reaction:

Name: Date:

Surgical History (check all that apply)

☐ Angioplasty	☐ Debridement	☐ Lumpectomy
☐ Arthroscopy	☐ Dilation and Curettage	☐ Mastectomy
☐ Appendectomy	☐ Ear Tubes	☐ Pacemaker/Defibrillator
☐ Biopsy (site):	☐ Eye Surgery (specify):	☐ Skin Lesion Removal
☐ Bunionectomy	☐ Gallbladder Removal	☐ Spinal Surgery (type):
☐ Cardiac Surgery (type):	☐ Gastric Bypass	☐ Thyroid Surgery
☐ Carpal Tunnel	☐ Hernia	☐ Tonsillectomy
☐ Cesarean Section	☐ Hysterectomy	☐ Tubal Ligation
☐ Colostomy	☐ Joint Replacement	☐ Vasectomy
☐ Cosmetic (type):	☐ Kidney Surgery	☐ Other:

Check all that apply. Please indicate family member associated with condition: M-Mother, F- Father, S-Sister, B- Brother, MG- Maternal Grandmother, MF- Maternal Grandfather, MA- Maternal Aunt, MU- Maternal Uncle, PG- Paternal Grandmother, PF- Paternal Grandfather, PA- Paternal Aunt, PU- Paternal Uncle, C- Child

Family History

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ ADD/ADHD		☐ Diabetes		☐ Obesity	
☐ Alcoholism/Substance Abuse		☐ Eczema/Psoriasis		☐ Parkinson's Disease	
☐ Alzheimer's/Dementia		☐ Heart Disease		☐ Psychiatric Disorder	
☐ Arthritis		☐ Hemodialysis		☐ Seizure Disorder	
☐ Asthma		☐ Hepatitis		☐ Stomach or GI problems	
☐ Auto Immune Disease (ex: Lupus)		☐ High Blood Pressure		☐ Stroke/TIA	
☐ Cancer (type):		☐ High Cholesterol		☐ Thyroid Problems	
☐ COPD		☐ Kidney Disease		☐ Other:	

Social History

<table>
<tr>
<td>Exercise Habits:

☐ Daily ☐ Minimal
☐ 3-4 x per week ☐ None
☐ 1-2 x per week ☐ None Due to Injury/Illness</td>
<td>Tobacco Use:

☐ Never Smoked ☐ Smokeless Tobacco
☐ Current Smoker ☐ Vaporizer
☐ Former Smoker Amt/Day _____ # of years
_____</td>
<td>Alcohol Use:

_____ Drinks Per Week

Caffeine Use:

_____ Cups Per Day</td>
</tr>
<tr>
<td>Drug Use:

☐ No history of recreational drug use
☐ Former use of recreational drugs
☐ Current use of recreational drugs</td>
<td colspan="2">Work Habits: ☐ N/A
Average # of hours per week _____
Mostly- ☐ Sitting ☐ Standing ☐ Walking
Labor- ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy
Environment- ☐ Difficult ☐ Stressful ☐ Relaxed ☐ Enjoyable</td>
</tr>
</table>

Name: Date:

Review of Systems (check all that apply)

CONSTITUTIONAL	ENDOCRINE	HEMATOLOGY/LYMPH	CARDIOVASCULAR
☐ Weight Loss ☐ Fatigue ☐ Fever	☐ Loss of Hair ☐ Heat/Cold Intolerance	☐ Bruising ☐ Gums Bleed Easily	☐ Murmur ☐ Chest Pain ☐ Palpitations
EYES	**GASTROINTESTINAL**	**MUSKULOSKELETAL**	☐ Dizziness ☐ Fainting Spells ☐ Shortness of Breath ☐ Difficulty Lying Flat ☐ Swelling Ankles
☐ Glasses/Contacts ☐ Eye Pain ☐ Double Vision ☐ Cataracts	☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in bowel movements	☐ Joint Pain Swelling ☐ Stiffness ☐ Muscle Pain ☐ Back Pain	
EAR, NOSE, THROAT	**GENITOURINARY**	**NEUROLOGICAL**	
☐ Difficulty Hearing ☐ Ringing in the Ears ☐ Vertigo ☐ Sinus Trouble ☐ Nasal Stiffness ☐ Frequent Sore Throat	☐ Burning/Frequency ☐ Night Time ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Abnormal Discharge ☐ Bladder Leakage	☐ Loss of Strength ☐ Numbness ☐ Headaches ☐ Tremors ☐ Memory Loss	
RESPIRATORY	**PSYCHIATRIC**	**SKIN**	
☐ Cough Easy ☐ Wheezing ☐ Chills	☐ Anxiety/Depression ☐ Mood Swings ☐ Difficulty Sleeping	☐ Rash/Sores ☐ Lesions ☐ Itching/Burning	