

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____
Date of Birth: _____ SSN#: _____
Home address: _____ PO BOX: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Gender at birth: M F Current Gender Identification: _____
Marital Status: Married Single Divorced Widowed
Race: African American Asian/Pacific Islander Caucasian Hispanic Native American Other
Ethnicity: Hispanic Non-Hispanic Preferred Language: English Spanish Other
Email: _____ Employer: _____
Occupation: _____ Work Phone: _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Provider: _____ Phone Number: _____
Referring Provider: _____ Phone Number: _____
Is this a DIRECT ACCESS (no referral) visit? Y N

EMERGENCY CONTACT INFORMATION

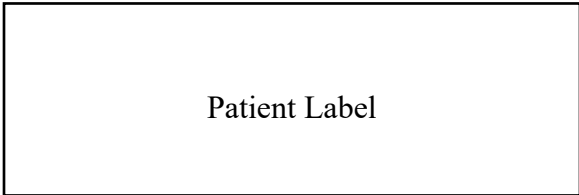
By listing the individual below as an emergency contact, you are authorizing our staff to release information regarding the nature of the emergency and your location.

Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

No need to fill this out if insurance card is presented at time of your initial evaluation.

Insurance Provider: _____
Insurance Phone Number: _____
Insurance Address: _____
Policy # _____ Group # _____
Policy Holder Name: _____ DOB: _____
Policy Holder Relationship to patient: _____



RESPONSIBLE PARTY/ GUARANTOR INFORMATION

Please complete if patient is under the age of 18 or if you would like billing information sent to someone other than the patient.

Name: _____ Relationship: _____
SS#: _____ Guarantor DOB: _____
Home address: _____ PO BOX: _____
City: _____ State: _____ Zip: _____
Contact Number: _____ Employer: _____

RELEASE OF INFORMATION

By listing the following names, you are granting permission for us to share your information with them.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Do you grant us permission to leave messages for you regarding your healthcare or appointments on your phone voicemail? Y N

Do you grant us permission to send text messages regarding upcoming appointments? Y N

Number to text: (_____) _____

X _____
Signature of Patient or Legal Representative Relationship to Patient Date

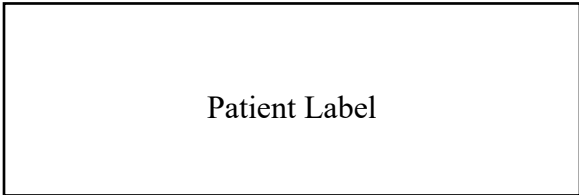
CANCELLATION POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. We understand that unavoidable circumstances may cause you to cancel within 24 hours, and these situations will be considered on a case by case basis.

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients that NO SHOW two (2) times will be subject to a \$50.00 fee. Patients who NO SHOW three (3) times may be dismissed from the practice, thus they will be denied further appointments. The No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Fees may be paid with cash or credit card. Please sign that you have read, understand, and agree to this Cancellation and No Show policy.

X _____
Signature of Patient or Legal Representative Relationship to Patient Date

If you would like a copy of the Cancellation and No Show policy to retain for your personal records, please let the receptionist know.



PROBLEM AND/OR ACCIDENT & INJURY

Is this visit a result of an accident or an injury? Y N

If this is an injury was it due to: motor vehicle accident worker's compensation other

If this was an injury, how did it occur? _____ Date: _____

Where did the injury take place (city/state)? _____ Time _____

Is there legal action pending related to your problem? Y N

Have you had any treatments or tests for this injury prior to today's visit? Y N

- X-Rays MRI Bone Scan Nerve Conduction Testing Other

HISTORY OF PRESENT ILLNESS

Body part being seen for today: _____ LEFT RIGHT

Please rate your pain on a scale of 0-10, 10 being the worst: _____

How long have you had this pain? _____ day(s) week(s) month(s) year(s)

Describe your symptoms: _____

How does your pain feel? Aching Burning Dull Sharp Throbbing Other

How often do you have pain? Consistent Intermittent Occasional Rare Other

Does your pain radiate? Y N Radiates to where? _____

Is your pain aggravated by:

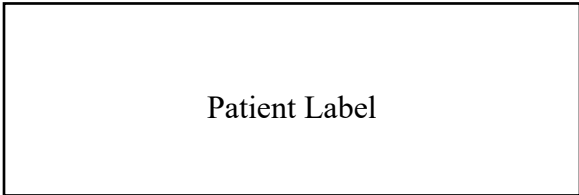
- Nothing Pulling Weight Bearing Squatting
- Lifting Throwing Walking Bending
- Overhead Motion Weather Running Prolonged Sitting
- Pushing Movement Stairs Other _____

Treatments that you have tried for current problem:

- Nothing Tylenol Physical Therapy Crutches
- Rest Ibuprofen Brace Chiropractor
- Ice Aleve Cast Injections
- Heat Home Exercise Program Splint Meds

IF YOU ARE A STUDENT:

What sports do you plan on playing this year?



Current Medications (please list over-the-counter, vitamins and herbs)

Medication Name	Strength (mg)	Quantity (ex. 2 tablets)	Times/day

Personal Medical History (current and prior) CIRCLE ALL THAT APPLY

Cardiovascular	Vision	Mental Health
Angina (Chest Pain)	Blindness	Anxiety
Atrial Fibrillation	Cataracts	Depression
Congenital Heart Defects	Glaucoma	Muscular/Skeletal
Congestive Heart Failure (CHF)	Macular Degeneration	Bone/Muscle Disorder
Coronary Artery Disease	Stomach/Bowel/Liver/Kidney	Osteoarthritis
Heart Attack	Liver Disease/Cirrhosis	Rheumatoid Arthritis
Heart Stents	Colon Polyps	Osteoporosis
High Blood Pressure	GERD (acid reflux)	Neurological (Nerve/Brain)
High Cholesterol	Inflammatory Bowel Disease (IBS)	Migraine Headaches
Pacemaker	Stomach or Duodenal Ulcers	Neuropathy
Peripheral Artery Disease	Kidney Disease/Dialysis	Seizure Disorder/Epilepsy
Cancer	Hematologic / Infectious	Stroke
Type:	AIDS/HIV	Tremor/Balance Disorder
Treatment:	Anemia	Respiratory (Lungs)
Endocrine	Bleeding Disorder	Asthma
Adrenal Disease	Blood Clots / DVT / PE	Bronchitis or Pneumonia
Diabetes- Type 1/Type II	Hepatitis – Type	COPD/Emphysema
Thyroid Disease	MRSA Infection	Obstructive Sleep Apnea

Surgical History

Date	Procedure	Physician	Hospital

Patient Label