NEW PATIENT FORM

Please note: information you provide here is protected as confidential information.

Patient Information:

● Name: _____
(Last) (First) (Middle Initial)
*Name of parent/guardian (if under 18 years):*_____

● Date of Birth: _____ ● Sex: □ Male □Female ● Height: _____ Weight: _____
● Marital Status: □ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

● Home Phone: (__)_____ May we leave a message? □Yes □No
● Cell/Other Phone: (__)_____ May we leave a message? □Yes □No

● Address _____
City_____ State_____ Zip _____

● Employer:_____Occupation:_____
● Social Security Number: _____

● Referred by (if any):_____

● Emergency Contact Information:
Name: _____ Phone: _____
Relation: _____

Health History:

●Who is your Primary Medical Care Physician?_____
Phone Number and/or Name of Physician's office:_____

●Hospitalizations:_____
_____

●Surgeries (Type and Date): _____
_____
_____

●Medications:_____
_____
_____
_____

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●Family Medical History-*Please list all first-degree relatives who have experienced the following*:

Heart Attack:_____
Stroke:_____
Diabetes:_____
High Blood Pressure:_____
Cancer:_____
Sudden Death:_____
Other:_____

●Check if you have ever suffered from or are allergic to any of the following:

Allergies		Tuberculosis	
Asthma		Sexually Transmitted Disease	
AIDS/HIV		Mental Health Problem	
High Blood Pressure		Immune System Problems	
Thyroid Problems		Congestive Heart Failure	
Respiratory Problems		High Cholesterol	
Kidney Trouble		Heart Disease	
Migraines		Thyroid Disease	
Chronic cough		Stroke	
Coughing up blood		Arthritis	
Low Blood Sugar		COPD	
Epilepsy or Neurological Problems		Anesthesia	
Cancer		Sulfa Drugs	
Sinus Trouble		Narcotics	
Fainting Spells		Penicillin or Antibiotics	
Diabetes		Barbiturates	
Hepatitis/Jaundice/Liver Problems		Iodine	
Stomach Problems		Other	

IF YOU DO NOT HAVE A DOCTOR'S REFERRAL PLEASE ANSWER THE FOLLOWING:

●My injury is related to: □ Work □ Sports □ Auto □ Trauma □ Chronic
Please describe: _____

●Please briefly describe where you feel the pain, its location, and the kind of pain it is: _____
_____

● Have you seen a Medical Physician for your pain? □ Yes □ No
If yes, please list who and where_____