NEW PATIENT INFORMATION

NAME: _____ Preferred name: _____ Date of Birth: ____/_____/_____ Age: _____

Preferred Phone Number: _____

INSURANCE INFORMATION: Primary insurance: _____ Secondary insurance: _____

Primary Care / Family Doctor: _____ Address_____ Phone #: _____

PHARMACY: Please provide the name / cross streets or address / phone number of your preferred pharmacy:
Name: _____ Address: _____ Phone #: _____

How did you come to find out about this office?:

❑ Doctor's suggestion (by Dr. _____) ❑ friend/relative recommendation (_____)
❑ Self-referral / Insurance web site ❑ other: _____

PAST/CURRENT MEDICAL HISTORY ❑ see list for: _____

Medications Name and Dose ❑ NONE	**Current Medical Conditions:** ❑ NONE	**Prior Surgeries:** ❑ NONE	**Allergies:** ❑ NONE
1. _____	1 _____	1. _____	1. _____
2 _____	2 _____	2 _____	2 _____
3. _____	3_____	3. _____	3. _____
4. _____	4 _____	4. _____	4. _____
5. _____	5 _____	5._____	5. _____
6. _____	6 _____	1. _____	6. _____
7. _____	7 _____	2. _____	7. _____

Social History:
Work Status: ❑ retired ❑ actively working ❑ unemployed ❑ on disability ❑ laid-off ❑ homemaker ❑ student: _____ (school)
Employer: _____ Occupation / Title: _____
Tobacco Use: ❑ non-smoker ❑ quit ❑ cigarettes ___ pack/day ❑ chew ❑ pipe ❑ cigars
Current illicit drug use: ❑ YES ❑ NO
Alcohol use: ❑ NO ❑ YES: (number of drinks) ____ beer ___ wine ___ liquor … per … ❑ day ❑ week ❑ month
Do you exercise regularly? ❑ NO ❑ YES (circle) walking/ running/ biking/ weights/ other_____ for ____ min ____ days/week
If you play organized sports, tell me the team name/sport/position: _____

Family History: do any of your immediate family members have any of these conditions. Please indicate relation (mom, dad, grandparent, brother, sister…)

	Relation		Relation:		
❑ diabetes	_____	❑ Gout	_____	❑ other diagnosis:	
❑ heart disease	_____	❑ psoriasis	_____	_____	
❑ osteoporosis	_____	❑ rheumatoid arthritis	_____	❑ osteoarthritis:	
❑ Lupus	_____	❑ joint replacement	_____	joint(s) _____	
❑ bone cancers	_____	❑ Leukemia	_____	❑ other Cancer (kind)	

REVIEW OF SYMPTOMS: Do you *currently* have or *in the last month* have had any of the following signs or symptoms of illness:
❑ NONE

Constitutional:	**Eyes:**	**Ears/Nose/Mouth:**	**Respiratory:**	**Cardiovascular:**	**Gastrointestinal:**	**Allergic/Immunologic:**
❑ fevers	❑ tearing	❑ hearing loss	❑ cough	❑ chest pain	❑ heartburn	❑ sneezing
❑ weight loss	❑ visual disturbance	❑ nose bleeds	❑ sputum	❑ palpitations	❑ stomach pain	❑ watery eyes
❑ fatigue	❑ dry eye	❑ nasal congestion	❑ wheeze	❑ passing out	❑ bloody/black stool	❑ hives
❑ anorexia	❑ double vision	❑ sore throat	❑ shortness of breath	❑ heart murmur	❑ constipation	❑ itching
	❑ eye pain	❑ dry mouth	❑ coughing blood	❑ exertion fatigue	❑ diarrhea	❑ anaphylaxis

Musculoskeletal:	**Neurologic:**	**Genitourinary:**	**Endocrine:**	**Skin/Breast:**	**Psychological:**	**Hematologic/Lymph:**
❑ back pain	❑ numbness/tingling	❑ painful urination	❑ cold/hot intolerance	❑ rash	❑ stress	❑ easy bruising
❑ joint looseness	❑ dizziness	❑ blood in urine	❑ hair loss	❑ jaundice	❑ depression	❑ swollen ankles
❑ muscle pain	❑ poor balance	❑ discharge	❑ frequent thirst	❑ dry skin	❑ anxiety	❑ swollen glands
❑ AM stiffness	❑ headache	❑ night time urination	❑ night sweats	❑ nail changes	❑suicidal ideations	❑ prolonged bleeding
❑ joint swelling	❑ seizures			❑ breast lump	❑ abusive relationship	

❑ Reviewed By Physician:_____

PLEASE TURN PAGE OVER

NAME: _____ **BIRTH DATE:** _____

TELL US ABOUT THE REASON YOU ARE BEING SEEN TODAY:

What body parts are involved?

What date did your injury happen or pain first start? (approximately)
_____/_____/_____

Or has been present for:
_____ (days/weeks/months/years)

UPPER BODY		LOWER BODY		BACK
Shoulder	❑ Rt ❑ Lt	Hip	❑ Rt ❑ Lt	❑ Neck (cervical spine)
Upper Arm	❑ Rt ❑ Lt	Thigh	❑ Rt ❑ Lt	❑ Mid back (thoracic spine)
Elbow	❑ Rt ❑ Lt	Knee	❑ Rt ❑ Lt	❑ Low back (lumbar spine)
Forearm	❑ Rt ❑ Lt	Lower Leg	❑ Rt ❑ Lt	❑ Buttocks (sacral spine)
Wrist	❑ Rt ❑ Lt	Ankle	❑ Rt ❑ Lt	
Hand	❑ Rt ❑ Lt	Foot	❑ Rt ❑ Lt	
Finger/Thumb	❑ Rt ❑ Lt	Toe	❑ Rt ❑ Lt	

TELL ME ABOUT YOUR PROBLEM:

Are there any other associated symptoms: ❑ swelling ❑ weakness ❑ giving out/buckling ❑ locking ❑ popping ❑ stiffness ❑ warmth ❑ redness ❑ numbness/tingling; any other details: _____

Have you ever had a similar problem before? _____

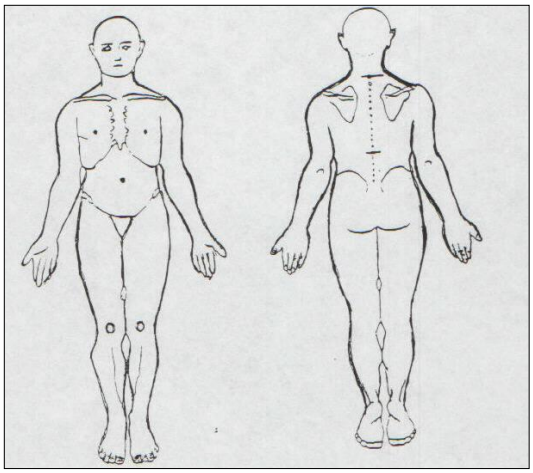
UPPER BODY / ARM PROBLEM QUESTIONS:

Are you LEFT HANDED ❑ or RIGHT HANDED ❑
Can you lift a gallon of milk out of the refrigerator? ❑ Yes ❑ Yes, with pain ❑ No
Do you have any neck pain? ❑ No ❑ Yes: _____
Does the pain keep you from sleeping or wake you from sleep? ❑ No ❑ Yes

LOWER BODY / LEG Problem Questions:

(Knee) Do you have pain if you kneel on the ground ❑N ❑Y; Squat down? ❑ N ❑ Y
Stiffness after sitting or inactivity ❑ No ❑ Yes
Discomfort if sitting with knees bent for long periods (ie Movie, Long Car Rides…)
Pain with going UP STAIRS / DOWN STAIRS (Circle)
(Ankle) Increased pain with walking over uneven surfaces (rocks, sand…)
Clicking and popping ❑ No ❑ Yes
(Foot) Pain with the first step out of bed in the morning? ❑ No ❑ Yes
Increased symptoms with certain shoes? Kind: _____
Have you ever worn orthotics: _____
(General) If you are a runner, how often do you get new running shoes _____

Please indicate where specifically you feel pain:



What other treatments for this problem have you had?

- ❑ Cortisone Injection: _____
- ❑ Physical therapy: _____
- ❑ Surgery: _____
- ❑ Medicine: _____
- ❑ Cane / Crutch: _____
- ❑ Brace: _____
- ❑ Other: _____

What other evaluations have you had?

- ❑ X-ray:_____
- ❑ MRI / CAT_____
- ❑ EMG / nerve study_____
- ❑ Chiropractor:_____
- ❑ Other: _____
- ❑ NONE: _____

I certify that the above information is accurate and complete to the best of my knowledge I will not hold my doctor or any members of his or her staff responsible for any errors or omissions that I have made in completion of this form.

Patient or Legal Guardian signature: _____ **Date:** _____

Reviewed by / Physician signature: _____ Date: _____

Physician Use Only:

History:	Exam:	Other:
	I:_____ P:_____ M:_____ S:_____ T:_____ O:_____	