PATIENT INFORMATION SHEET

Patient Name:		**Date of Birth:**	Marital Status:
Address:		Sex:	Soc. Sec.#:
City:	St:	Zip:	Do we have your permission to leave information related, but not limited, to appointment, billing, negative test results on answering machine/ voicemail at? ***(please check box)***: ☐ Home ☐ Cell ☐ Work ☐ No
Home Ph.#:	Cell Ph.#:	Work Ph. #:	Place of Employment:
Email Address:		Worker's Comp? ☐ Yes ☐ No	Date of Injury: _____

RACE: ***(Please Check appropriate boxes)***

☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

Primary Language:

Ethnicity(*please check box)*)

☐ HISPANIC/LATIN AMERICAN ☐ REFUSED TO REPORT ☐ NON-HISPANIC/LATIN

Responsible Party (if other than patient):		Sex:	Date of Birth:
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.#:	Cell Ph. #:	Work Ph.#:

Emergency Contact Name: (Outside the household) **:**

Home Ph.#:	Cell Ph.#:	Relationship:

***Insurance cards, photo ID and co-payments must be presented at time of service.**	***Insurance cards, photo ID and co-payments must be presented at time of service.**
INSURANCE NAME	**INSURANCE NAME**
SUBSCRIBER NAME	**SUBSCRIBER NAME**
DOB SS#	**DOB SS#**

Medical History

Patient Name: _____ Employer: _____ Phone #: _____

Reason You Are Being Seen Today: _____ Onset Date: _____

Height: _____ Weight: _____ Pain Level Today 1 – 10 (with 10 being the worst): _____

Medications (or provide list): _____

_____

_____

_____

History of Present Illness

Day of Injury or Onset of Pain: _____ Activity at Time of Injury: _____

Pain Duration: ☐ Minutes ☐ Hours ☐ Days ☐ Constant ☐ Intermittent

Pain Quality: ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Spasm ☐ Other

Pain Radiation: ☐ None ☐ Head ☐ Shoulders ☐ Arms ☐ Legs ☐ Other

Symptoms Exacerbated by: ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Other

Symptoms Improved by: ☐ Standing ☐ Sitting ☐ Lying Down ☐ Other _____

Mechanism of Injury: ☐ Sports-related ☐ Trauma-related ☐ Work-related ☐ Other _____

Current Therapy: ☐ None ☐ Cold Therapy ☐ Heat Therapy ☐ Physical Therapy

Pertinent Past History:

☐ Neck Trauma	☐ Back Injury	☐ Head Trauma	☐ Degenerative Disk Dis.
☐ Recent Surgery	☐ Arthritis	☐ Osteoporosis	☐ Diabetes Mellitus
☐ Infection	☐ Cancer	☐ Genetic Syndrome	☐ Peripheral Vascular Dis.
☐ Fractures	☐ Aneurysm	☐ Autoimmune Disease	☐ Psychiatric Disorders

Past Medical History (Please X if you have these or have a history of a certain condition.)

List Allergies & Reactions (rash, itching, etc.): _____

_____

Have you ever tested positive to MRSA? ☐ Yes ☐ No

Past Medical History (Continued)

Endocrine: ☐ Diabetes ☐ Hypothyroidism

Respiratory: ☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ Shortness of Breath

Cardiovascular: ☐ Atrial Fibrillation ☐ Coronary Artery Disease ☐ Heart Failure
☐ Hypertension ☐ Myocardial Infarction ☐ Chest Pain

Gastro: ☐ GERD ☐ Peptic Ulcer Disease

Genitourinary: ☐ Kidney Stones ☐ Males: Benign Prostate Hyperplasia

Musculoskeletal: ☐ Fibromyalgia ☐ Rheumatoid Arthritis ☐ Fractures (list) _____
☐ Arthritis ☐ Osteoporosis ☐ Amputations (list) _____

Oncology: ☐ Anemia ☐ Blood ☐ Brain ☐ Breast ☐ Colorectal
☐ Endocrine ☐ GI ☐ Leukemia ☐ Liver ☐ Lung ☐ Lymphoma
☐ Prostate ☐ Skin ☐ Stomach ☐ Thyroid ☐ Other _____

Neurologic: ☐ Dementia ☐ Multiple Sclerosis ☐ Parkinson Disease ☐ Restless Leg Syndrome
☐ Seizures ☐ Strokes ☐ Aneurysm ☐ Migraines ☐ Sciatica

Psychiatric: ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Drug Abuse ☐ Suicidal Ideation

Tobacco Use: ☐ Non-smoker ☐ Smoker: ____ Packs per Day

Alcohol Use: ☐ None ☐ 0 – 2 per Day ☐ 2+ per Day

Substance Use: ☐ None ☐ Amphetamines ☐ Tranquilizers/Sedatives ☐ Opiates
☐ Painkillers ☐ Injection Drugs ☐ Other _____

Past Surgical History

Endocrine: ☐ Parathyroidectomy ☐ Thyroid Surgery ☐ Other _____

Cardiovascular: ☐ Angioplasty ☐ Coronary Stent ☐ Heart Transplant
☐ Pacemaker ☐ Valve Replacement ☐ Other _____

Gastrointestinal: ☐ Appendectomy ☐ Colectomy ☐ Gastric Bypass ☐ Hernia Repair

Musculoskeletal: ☐ Knee Replacement (R or L | Year _____) ☐ Hip Replacement (R or L | Year _____)
☐ AKS (R or L | Year _____) ☐ Spinal Surgery ☐ Other _____