Welcome to our office!

NEW PATIENT INFORMATION

NAME (first, middle, last):____________________

MAILING ADDRESS:____________________ CITY: __________ STATE: _____ ZIP: __________

EMAIL ADDRESS: ____________________ SS#_____-_____-______ DOB:__________

HOME PHONE:__________ CELL PHONE:__________ SEX: M_____ F_____

EMPLOYER: ____________________ WORK PHONE:__________

RESPONSIBLE PARTY: __________ RELATIONSHIP TO PATIENT: __________

ADDRESS:____________________ __________ SS#: _____-_____-______ DOB:__________

EMERGENCY CONTACT (who does not live with you): ____________________

ADDRESS:____________________ PHONE: __________

WHOM MAY WE THANK FOR THIS REFERRAL? ____________________

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME:____________________RELATIONSHIP TO PATIENT:__________

SUBSCRIBER ADDRESS:____________________ CITY: __________ STATE: _____ ZIP: __________

DOB:____/____/_____ SS#:_____-___-_______ EMPLOYER:____________________

INSURANCE CO:____________________

INSURANCE ADDRESS:____________________

ID#: ____________________ GROUP #:__________ __________

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME:____________________RELATIONSHIP TO PATIENT:__________

SUBSCRIBER ADDRESS:____________________ CITY: __________ STATE: _____ ZIP: __________

DOB:____/____/_____ SS#:_____-___-_______ EMPLOYER:____________________

INSURANCE CO:____________________

INSURANCE ADDRESS:____________________

ID#: ____________________ GROUP #:__________ __________

We invite you to discuss with us any question regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee the New Patient Information Form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. With my signature below, I hereby understand and authorize the statements above.

Signature: ____________________ Date: __________

MEDICAL HISTORY FORM

Patient Name: ______________________________ Date: ______________

1. **Chief Complaint**: ______________________________
   Complaint began when and how? ______________________________
   Have you had this pain before? ______________________________
   Please circle the Quality of the complaint/pain: (circle all that apply)
   dull aching sharp shooting burning throbbing deep nagging other ________
   Does this complaint/pain radiate or travel (shoot) to any areas of your body? _____Where?______________
   Do you have any numbness or tingling in your body? Where? ______________________
   How frequent is complaint present, how long does it last? ______________________
   Is your complaint getting better, getting worse, or unchanged since it began? ______________
   Is there any daily activity you have difficulty with or can no longer do? ______________
   Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint)
   Does anything aggravate the complaint? ______________________
   Does anything make the complaint better? ______________________

2. **Previous physicians you've seen or interventions, treatments, medications, or surgery you've sought for your complaint:**
   ____
   ____

3. **Past Health History:**
   A. Previous illnesses you've had in your life: ______________________
   B. Previous injury or fractures: ______________________
   C. Allergies ______________________
   D. Medication — Reason for taking

Medication	Reason for taking
________	________
________	________
________	________

   E. Surgeries:
   ____

   F. Do you have or ever have had any of the following diseases or conditions ?

Y/N	Frequent Neck Pain	Y/N	Hepatitis	Y/N	Asthma
Y/N	Numbness	Y/N	Cancer	Y/N	Diabetes
Y/N	Dizziness	Y/N	Anemia	Y/N	Difficulty Breathing
Y/N	Lower Back Problems	Y/N	High / Low Blood Pressure	Y/N	Chemotherapy
Y/N	Severe / Frequent Headaches	Y/N	Psychiatric Problems	Y/N	Artificial Bones / Joints
Y/N	Neuritis	Y/N	Rheumatic Fever	Y/N	Arthritis
Y/N	Heart Attack / Stroke	Y/N	Kidney Problems	Y/N	Depression
Y/N	Heart Surgery / Pacemaker	Y/N	Ulcers / Colitis		
Y/N	Heart Murmur	Y/N	Fainting / Seizures / Epilepsy		
Y/N	Congenital Heart Defect	Y/N	Sinus Problems		

4. **Family Health History:**
   Associated health problems of relatives: ______________________
   Deaths in immediate family:

Cause of parents or siblings death	Age at death
________	________
________	________
________	________

5. **Occupational History**:
   A. Job physical demands: ______________________________

6. **Other**
   Do you have a pacemaker?______________ Family history of kidney stones?______________
   Are you or is there a chance that you might be pregnant? ______________
   Have you lost any days of work? ______________