Name: _____ **Birthdate:** _____ **Chart #** _____

Sex: ☐ M ☐ F Age_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

SS# _____ Spouse/Partner Name_____

Address: _____

City: _____ State:_____ Zip_____

Home #: _____ Cell#:_____

Primary Care Physician:_____ Phone:_____ Date last seen:_____

Employer: _____ Work #: _____

Address: _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ M ☐ F Birthdate _____

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ M ☐ F Birthdate _____

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other _____

What is the reason for your visit today?_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling

other: _____

DATE:

History and Physical

Medical History: Place a mark on "Yes" or "No" to indicate if you have **HAD** any of the following :

Liver Disease	□ Yes □ No	Gout	□ Yes □ No	Diabetes:	□ Yes □ No
Heart Murmur	□ Yes □ No	Depression	□ Yes □ No	(Circle one:)	Type 1 , Type 2
Blood Clot	□ Yes □ No	Thyroid Disease	□ Yes □ No	HIV	□ Yes □ No
Neuropathy	□ Yes □ No	Circulatory Problems	□ Yes □ No	Skin Disorders	□ Yes □ No
Arthritis	□ Yes □ No	Anxiety	□ Yes □ No	Breathing Problems	□ Yes □ No
Alcoholism	□ Yes □ No	High Blood Pressure	□ Yes □ No	Asthma	□ Yes □ No
Sleep Apnea	□ Yes □ No	Heart Disease	□ Yes □ No	Kidney Problems	□ Yes □ No
High Cholesterol	□ Yes □ No	Mental Illness	□ Yes □ No	Hepatitis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Cancer	□ Yes □ No	Stroke	□ Yes □ No

Other (Please Specify):_____

Female patients only: **Are you pregnant?** □ Yes □ No **Are you nursing?** □ Yes □ No

Family History *Is there any immediate family history of: (Please indicate immediate family member)*

□ Alzheimer's	_____	□ Cataracts	_____	□ Heart Disease	_____
□ Arthritis	_____	□ Circulation problems	_____	□ High Blood Pressure	_____
□ Bleeding disorders	_____	□ Depression	_____	□ Neurological	_____
□ Blood Clot	_____	□ Diabetes:(Type 1/Type 2)	_____	□ Strokes	_____
□ Cancer	_____	□ Emphysema	_____	□ Other (*specify*)	_____

Social History

Do you smoke? □ Yes □ No If yes, how many packs per day? □ 1 □ 2 □ 3 □ 4 □ 5 For how long?_____

Do you drink alcohol? □ Yes, everyday (5-7 days/week) □ Yes, occasionally/socially □ No, rarely

Substance abuse: □ Yes, I have a current substance abuse problem. Please specify: _____

□ Yes, I had a past substance abuse problem. Please specify:_____

□ No, I have never had a substance abuse problem.

Surgical History □ None

Please list ***any*** surgeries you have had: _____

_____

_____

Do you have any artificial joints? □ Yes (where ? _____) □ No Do you have an artificial heart valve? □ Yes □ No

Review of Systems: *(Please check the box if you **CURRENTLY** have any of these symptoms)*

Cardiovascular	□ chest pain/pressure	□ fainting	□ leg pain when walking	□ palpitations	
	□ cold hands/feet	□ fever	□ leg swelling	□ valve problems	□ vascular disease
Gastrointestinal	□ abdominal pain	□ constipation	□ diarrhea	□ increased appetite	□ vomiting
	□ blood in stool	□ decreased appetite	□ heartburn	□ trouble swallowing	□ ulcers
Hematologic	□ anemia	□ blood thinners	□ clotting disorders	□ lower leg ulcers	□ sickle cell disease
Integumentary	□ athletes foot	□ dry, scaly skin	□ itchiness	□ keloids	□ nail abnormalities
Musculoskeletal	□ arthritis	□ joint instability	□ joint stiffness	□ muscle pain	□ neck pain
	□ back pain	□ joint pain	□ joint swelling	□ muscle weakness	□ sciatica
Neurological	□ headaches	□ numbness	□ paralysis	□ seizures	□ tingling □ tremors □ weakness
Respiratory	□ chest pain	□ COPD	□ coughing	□ emphysema	□ snoring □ wheezing

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. _____

(Patient Signature)