WELCOME TO OUR CLINIC

Confidential Patient Information

The following information is needed in order to better serve you. Please complete ***ALL*** questions. If you need help please ask the receptionist. ***PLEASE PRINT CLEARLY***

Name ____ Today's Date _________________

Address ____________________________Apt #______ Home phone (___)______________

City ________________ State ____ Zip _______ Pager/Cell Phone (____)____________

Age ____ Date of birth _________________ Sex____ Marital status: S M W D

Social Security # ______________________ Driver's License # ______________________

E-mail address(es)____

Reason for today's visit ____

Is this due to an accident or injury? Yes No If yes, date of accident_______________

Type of accident: Auto Work Home Slip & Fall Other_________________________

Has this injury been reported to ***YOUR*** insurance company and/or employer? Yes No

Employer __________________________ Occupation ______________ Years on job ___

Work address ______________________________ City _________ State ____ Zip ______

Work phone (____)______________ Do you have health insurance at work? Yes No

Insurance company _____________________________ Plan/Group # ________________

Emergency contact name ________________________ Relationship ________________

Address ____ Phone (____)_______________

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance. On all insurance, the deductible must be met in the beginning unless prior arrangements are made. I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand and agree that if I suspend or
terminate my care and treatment, any fees for professional services rendered me, will be immediately due and payable. I certify that all information provided by me is true and accurate to the best of my knowledge.

Patient's Signature ______________________________________ Date _____________________

Spouse or Guardian's Signature ________________________________ Date _____________________

REV 10/05

Patient's Name:_________________________

Spouse's or Parent's Information

Name of spouse or parent _____________________________ Birth date ____________

Their employer ____ Years on job ____

Their employer's address ____________________ City _________ State ____ Zip ____

Their work phone (____)________________Their Social Security#_________________

List all of ***your current*** complaints or health problems, including any ***ALLERGIES*** you have:

List any other doctors seen and dates and type of treatment received for above conditions:

List ***all*** dates and surgeries you have had in the past:

List any medications (prescription ***or*** over the counter) you are ***now*** taking:

Have you ever been involved in an automobile accident? Y N When? (List all dates)

Have you ever been in a work-related accident or any other injury for which you have received treatment? Y N Date(s): Please provide details of each injury:

Please check any of the following conditions you now have or may have had:

____ Rheumatoid Arthritis ____ Hepatitis-Type:__ ____ Pace Maker
____ Metallic Implants ____ HIV Positive ____ AIDS

Patient's Name ___________________________

SOCIAL HISTORY

My **diet** is: ___ Balanced___ Not balanced ___ My **rest** is: ___ Sufficient ___ Not sufficient

My **recreation** is: ___ Sufficient ___ Not sufficient

How do you like **your job**: ___ Very much ___ It's ok ___ I hate it

My **family stress** is: ___ normal ___ low ___ Moderate ___ Severe

My **job stress** is: ___ Minimal ___ Moderate ___ Severe

___ **Smoking**; # / day = ___ **Other tobacco** use ___ **Alcohol** use ___ **Coffee or tea**

PLEASE SHOW US WHERE IT HURTS

On the line below, indicate where your level of pain is **NOW**:

0 1 2 3 4 5 6 7 8 9 10

0= no pain 5=moderate pain 10=worst imaginable pain

Please mark the area(s) showing the type of discomfort you have using the provided markings. Place the appropriate markings on the region of discomfort.

Numbness	Pins & Needles	Burning	Aching	Stabbing	Dull Pain	Tingling
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