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Patient Information Form

(Please print)

Date: __/__/____

Patient Name: _____ Date of Birth: __/__/____

(Last) (First) (M.I.)

Age:___ Sex: Male Female Race:_____ Ethnicity:_____

Home Address: _____ City/State:_____

Zip: _____ Email Address: _____

SSN: ___-___-____

How May We Contact You?

	May we Leave a Message?	Text?
Home Phone #: (___) ___-____	☐	☐
Work Phone #: (___) ___-____	☐	☐
Cell Phone # : (___) ___-____	☐	☐
Email: _____	☐	☐

Primary Language: _____

Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No

If yes, Name:_____ Relationship:_____

Phone #: (___) ___-____

Emergency Contact: _____Relationship:_____ Phone #: (___) ___-____

Primary Care Doctor: _____ Phone #: (___) ___-____

Pharmacy:_____ Location:_____ Phone #: (___) ___-____

Is there a family member or other person you would like for us to share your medical information?

▢ Yes Name(s): _____

▢ No

Who is responsible for payment?

▢ Self

▢ Other

Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____

Zip: _____ Phone #: (___) ___-____

Insurance Information

Primary Insurance Company: _____

Address: _____ City/State/P.O Box: _____

Zip: _____ Phone #: (___) ___-____

Insured Name: _____ Date Of Birth: __/__/____

Policy#: _____ Group #: _____

Secondary Insurance Company: _____

Address: _____ City/State/P.O Box: _____

Zip: _____ Phone #: (___) ___-____

Insured Name: _____ Date Of Birth: __/__/____

Policy#: _____ Group #: _____

How did you hear about us?

Referred by a Physician

Physician name: _____

Referred by a friend

Name of friend: _____ Relationship: _____

Contacted your insurance

Insurance company: _____

Found us online

☐ Our website ☐ Google Reviews ☐ Other Source

☐ Other source: _____

Found us through social media

☐ Facebook ☐ Twitter ☐ LinkedIn

☐ Other (Please describe)

_____

Social History

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Use of Alcohol: ◯ Never ◯ No Longer Use- How Long Ago_____

◯ Currently Use- ☐ Rare ☐ Occasional ☐ Moderate ☐ Moderate ☐ Weekly ☐ Daily

Use of Tobacco: ◯ Never ◯ No Longer Use- How Long Ago_____

◯ Currently Use- ☐ Rare ☐ Occasional ☐ Moderate ☐ Moderate ☐ Weekly ☐ Daily

Drug Use: ◯ Never ◯ No Longer Use- How Long Ago_____

◯ Currently Use- ☐ Rare ☐ Occasional ☐ Moderate ☐ Moderate ☐ Weekly ☐ Daily

Type of Drug: _____

Employer: _____ Occupation: _____

How much are you on your feet at work? ◯ 10% ◯ 25% ◯ 50% ◯ 75% ◯ 100%

Do others depend upon you for their care? Children-Age(s)_____

Pet(s)-What kind?_____ Elderly or Disabled family member

Other_____

Exercise: ◯ Never ◯ Rare ◯ Occasional ◯ Weekly ◯ Several Times A Week ◯ Daily

Type(s) of exercise: _____

Medical History

Allergies: Medications: _____

Anesthesia: _____ Foods: _____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other_____

☐ No Known

Family History: Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease

☐ Thyroid Disease ☐ Rheumatoid Arthritis ☐ Other_____

Have you ever had any of the following?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:											

Please list all prior surgeries:

Type of Surgery Date: Type of Surgery Date:

_____ _____

_____ _____

_____ _____

_____ _____

Please List All Prior Hospitalizations (Other than for surgery):

Reason For Hospitalization Date: Reason For Hospitalization Date:

_____ _____

_____ _____

_____ _____

Current Medications and Prescriptions

RX _____ Dosage: _____ RX _____ Dosage:_____

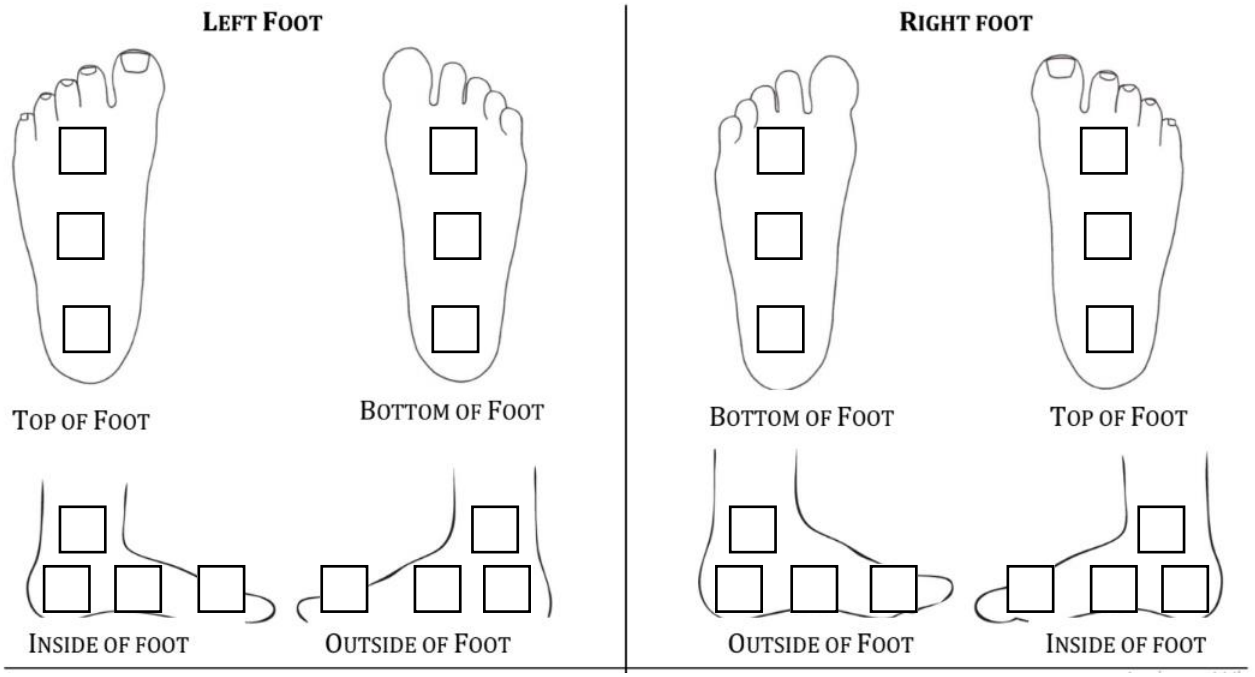
RX _____ Dosage: _____ RX _____ Dosage:_____

RX _____ Dosage: _____ RX _____ Dosage:_____

<u>Current Problem</u>

What specific problem(s) brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below:



How long ago did this problem first start? _____ ◯Days ◯Weeks ◯Months ◯Years

Did your pain or problem: ◯ Begin all of a sudden ◯ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other_____

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(No Pain) ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (Worst Pain Possible)

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities

☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe

☐ Running ☐ Other_____

What treatments have you had for this problem? _____

Was this problem caused by an injury? ◯ Yes (Describe) _____

◯ No

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print Name of Patient, Parent or Guardian	Signature of Doctor
If other than Patient, Relationship to Patient	Date
Signature	**Date**