# WELCOME

## PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____________________
First Name Middle Initial

Address ____________________

City ____________________

State ____________ Zip ____________

E-mail ____________________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____________________

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

## INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____________________
Signature of Patient, Parent, Guardian or Personal Representative

____________________
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

## PHONE NUMBERS

Home Phone (_____) ____________________

Cell Phone (_____) ____________________

Best time and place to reach you ____________________

**IN CASE OF EMERGENCY, CONTACT**

Name ____________________

Relationship ____________________

Home Phone (_____) ____________________

Work Phone (_____) ____________________

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date ____________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____________________

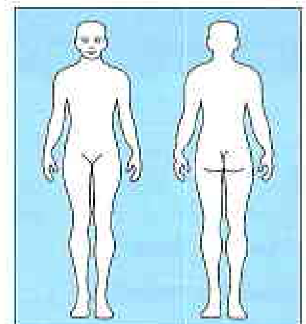
## PATIENT CONDITION

Reason for Visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down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# PATIENT HISTORY

Date____________________

Patient's Name ____________________ Date of Birth________________ Age ________

Occupation ________________________________

Marital Status: S M W D Ethnic Origin ________________

Last Year of School Completed __________

Allergies

| Medicinal | Other |
|---|---|
| | |
| | |
| | |
| | |

| Current Medications | Recurrent Problems |
|---|---|
| | |
| | |
| | |
| | |

## Tests & Immunizations

Blood Profile ____________________

Breast Exam ____________________

Breast Mammography ____________________

CBC ____________________

Chest X-Ray ____________________

Cholesterol Triglycerides ____________________

Complete Physical ____________________

EKG ____________________

Enlarged Heart ____________________

Flu Shot ____________________

Genitalia Exam (Male) ____________________

Hearing Test ____________________

HIV Test ____________________

PAP Smear (Women) ____________________

Pneumonia Vaccine ____________________

Pulmonary Function ____________________

Rectal Exam ____________________

Sigmoidoscopy ____________________

Sodium & Potassium ____________________

Stool Occult Blood ____________________

Tetanus (DPT) ____________________

Treadmill Test ____________________

Urinalysis ____________________

Vision Test ____________________

Other____________________

***Expiration Date***

# PERSONAL HISTORY

## PERSONAL/FAMILY HISTORY

Number of Siblings

| PERSONAL | YES | WHEN | NO | FAMILY | YES | SPECIFIC MEMBER | NO |
|---|---|---|---|---|---|---|---|
| Abdominal bleeding | | | | | | | |
| Allergies | | | | | | | |
| Anemia | | | | | | | |
| Arthritis | | | | | | | |
| Asthma/Emphysema | | | | | | | |
| Back Disorders | | | | | | | |
| Backache | | | | | | | |
| Black Tarry Stools | | | | | | | |
| Bleeding Diseases | | | | | | | |
| Blood in Stool | | | | | | | |
| Blood in Urine | | | | | | | |
| Cancer | | | | | | | |
| Change in Bowel habits | | | | | | | |
| Chest Pain | | | | | | | |
| Colitis | | | | | | | |
| Constipation | | | | | | | |
| Convulsion | | | | | | | |
| Cough | | | | | | | |
| Coughing Blood | | | | | | | |
| Depression | | | | | | | |
| Diabetes | | | | | | | |
| Diarrhea | | | | | | | |
| Difficulty Swallowing | | | | | | | |
| Dizziness | | | | | | | |
| Double Vision | | | | | | | |
| Enlarged Heart | | | | | | | |
| Epilepsy | | | | | | | |
| Fainting Spells | | | | | | | |
| Gallstones | | | | | | | |
| Gall Bladder Disorder | | | | | | | |
| Glaucoma | | | | | | | |
| Headaches | | | | | | | |
| Heart Disease | | | | | | | |
| Heart Murmur | | | | | | | |
| Hepatitis | | | | | | | |
| Hoarseness | | | | | | | |
| High Blood Pressure | | | | | | | |
| Indigestion | | | | | | | |
| Irregular Heart Beat | | | | | | | |
| Kidney Infection | | | | | | | |
| Kidney Stone | | | | | | | |
| Leg Pain | | | | | | | |
| Lung Disease | | | | | | | |
| Lyme Disease | | | | | | | |
| Nocturia | | | | | | | |
| Nosebleeds | | | | | | | |
| Nervous Disorder | | | | | | | |
| Painful Urination | | | | | | | |
| Paralysis | | | | | | | |
| Phlebitis | | | | | | | |
| Pleurisy | | | | | | | |
| Pneumonia | | | | | | | |
| Pus in Urine | | | | | | | |
| Rheumatic Fever | | | | | | | |
| Shortness of Breath | | | | | | | |
| Stroke | | | | | | | |
| Swelling of feet | | | | | | | |
| Swollen/Painful Joints | | | | | | | |
| T.B. | | | | | | | |
| Thyroid Disease | | | | | | | |
| Ulcer | | | | | | | |
| Venereal Disease | | | | | | | |
| Vomited Blood | | | | | | | |
| Other | | | | | | | |

# PATIENT HISTORY

## Personal Habits

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential. Please rate your answer on a scale of 1 to 5 (1 = No/Never, 5 = Yes/Often.)

| | 1 | 2 | 3 | 4 | 5 | Elaborate |
|---|---|---|---|---|---|---|
| Exercise Regularly (3 to 4 x WK) | | | | | | |
| Wear Seat Belts | | | | | | |
| Use Drugs | | | | | | |
| Drink Alcohol | | | | | | |
| Smoke | | | | | | |
| Chew Tobacco | | | | | | |
| Experience Stress | | | | | | |
| Other | | | | | | |

WOMEN ONLY

Menstrual Periods: Age Onset ________ Regular? ________ Date Last Period Began ____________

Age Menopause ______________________

Difficulty with Periods? ☐ Yes ☐ No Specify ____________

Pregnancies: No. of Children: Born Alive_____ Cesarean_____ Premature_____ Stillborn_____ Miscarriages_____

Describe complications: ______________________

Have you ever been referred to a specialist? ☐ Yes (Please Elaborate) ☐ No

Have you ever been in an accident? ☐ Yes (Please Elaborate) ☐ No

Are there any environmental risks involved in your job or home environments? ☐ Yes (Please Elaborate) ☐ No

MILITARY SERVICE

Which branch of service did you serve in? ______________________

Length of enlistment: ________ From: ________ To: ________

Did you sustain any injuries? ☐ Yes (Please Elaborate) ☐ No

# PATIENT HISTORY

## OPERATIONS

| Operation | Complications | Date |
|---|---|---|
| Tonsillectomy ______ | Complications ______ | Date ______ |
| Appendectomy ______ | Complications ______ | Date ______ |
| Hernia Repair ______ | Complications ______ | Date ______ |
| Other ______ | Complications ______ | Date ______ |
| Cholecystectomy ______ | Complications ______ | Date ______ |
| Hysterectomy ______ | Complications ______ | Date ______ |
| Hemorrhidectomy ______ | Complications ______ | Date ______ |
| Other ______ | Complications ______ | Date ______ |
| Radiation therapy ______ | Where ______ | Date ______ |

## HOSPITALIZATIONS

| | Description | Hospital | Year |
|---|---|---|---|
| Illness (Kind) | ______ | ______ | ______ |
| | ______ | ______ | ______ |
| | ______ | ______ | ______ |
| Surgery (Kind) | ______ | ______ | ______ |
| | ______ | ______ | ______ |
| | ______ | ______ | ______ |
| Other (Reason) | ______ | ______ | ______ |
| | ______ | ______ | ______ |
| | ______ | ______ | ______ |

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.