



New Patient Information

Name: _____ Age: _____ Sex: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Weight _____ Height _____ Phone: _____ Cell: _____

Best Time to Call: _____ Which # _____ Email: _____

Social Security # _____ / _____ / _____ DOB: _____ Family Doctor: _____

Married Single Sep Divorced Widowed Spouse's Name: _____

Employer: _____ Spouse's Employer: _____

Employers Phone: _____ Parents Employer if Patient is Minor/Child: _____

Parents SS # if Patient is Minor/Child: (required) _____ Emergency Contact _____

Relationship to Minor/Child: _____ Phone: _____

Who may we thank for referring you to our office: _____

SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptom to occur?

When did the problem or symptom begin? _____

Have you seen another doctor for this problem? NO If yes, who? _____

What test/procedures have been performed? X-Ray MRI Surgery Hospitalization Other _____

Have you had this problem or symptoms in the past? NO If yes
explain _____

Have you tried any other treatments for this? NO If yes explain _____

Is the problem or symptoms getting worse? NO If yes explain _____

PLEASE PROVIDE US WITH A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARDS

✓

ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

- Arthritis Depression Pregnancy Seasonal Allergies Eye Pain-Strain
- Dizziness/Balance Ringing in the Ears Seizures Blurred Vision Anxiety
- Elevated Stress Fears/Trauma Headache Bleeding Gums Jaw Pain
- Chronic Fatigue Heart Disease Gall Stones Swallowing Difficulty Thyroid Problem
- Chest Pain Chest Congestion Anemia Hypertension Difficulty Walking
- Kidney Stones Diabetes Pancreatitis Sleep Disruption Irregular Heart beat
- Asthma/Bronchitis Gout Neck Pain/Spasm Stroke Hyper tension
- Mid-Back Pain Should/Elbow Pain Wrist/Hand Pain Low Back Pain Hip/Knee/Leg Pain
- Foot/Ankle Pain Abdominal Pain Groin/Rectal Pain Female Disorder Urinary Problems
- Skin Problems Broken Bones Digestive Problems Nausea-Vomiting Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ Full Time Part Time

What is your employment status? Working Sick Leave Unemployed Retired Temporary Disability
 Permanent Disability Last day of work _____

Do you use tobacco? NO YES Explain: _____

Do you consume alcohol? NO YES Explain: _____

Do you have a history of substance abuse? NO YES Explain: _____

List all Past Surgeries _____

List all Drug Allergies _____

List all current and past medications/drugs _____

Drug Name: _____

List all Physicians you have seen in the past 5 years?

Name: _____ For What: _____

Name: _____ For What: _____

Name: _____ For What: _____

Father Living Age: _____ Deceased-Cause of Death: _____

Mother Living Age: _____ Deceased-Cause of Death: _____

Brother Living Age: _____ Deceased-Cause of Death: _____

Brother Living Age: _____ Deceased-Cause of Death: _____

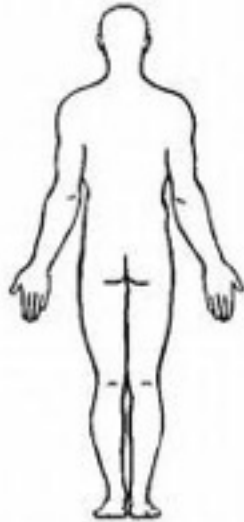
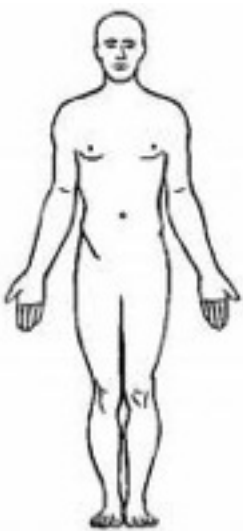
Sister Living Age: _____ Deceased-Cause of Death: _____

Sister Living Age: _____ Deceased-Cause of Death: _____

PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation

Describe your pain below (check all that apply)



Pain XXXX

Numbness ++++++

Burning //////////////

Ache *****

Pins and Needles or tingling -----

R

L

L

R

- Stabbing
- Dull Ache
- Sharp
- Throbbing
- Nightly/Sleeping

- While Resting
- Daily/Constant
- Deep Ache
- During Exercise/Work
- Other _____

Recurring

Tingling

Onset of Pain: Sudden Gradual

On a scale of 1 to 10 how would you rate your pain level today? _____ (1=Mild, 10=Intense)

ATTESTATION STATEMENT

By signing my name below, I agree that I have answered these above questions to the best of my acknowledgment and I have had read to me or I have read and fully understand these questions as it relates to my health.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____