PATIENT DEMOGRAPHICS

Name_____ ACCT#_____ DATE:_____
(First) (MI) (Last)

Birthdate_____ Age_____ Sex: Male Female Preferred Language: _____

Address_____ SSN_____
(Street) (City) (State) (Zip)

Home Ph._____ Cell Ph._____ Work Ph._____

Email_____

Race: __White/Caucasian, __Black/African American, __Native Hawaiian/Other Pacific Islander, __Asian, __Native American/Native Alaskan, Other: _____, __Decline

Ethnicity: __Spanish/Hispanic Origin, __Not of Spanish/Hispanic Origin, ___Decline

Pharmacy Name and Address: _____

(PCP) Primary Care Physician: _____ Ph#_____

Emergency Contact Person: _____ Relationship to Patient: _____

Home Ph._____ Cell Ph._____ Work Ph._____

*(If patient is a minor, Responsible party is: _____)

I was referred here by: _____ Website:_____

Friend/Family Member:_____ Other: _____

I am here today for my: RIGHT or LEFT BODY PART: _____.

My pain/problem began on: _____ This is a reoccurrence of an old problem: YES NO

If yes, please explain: _____

What is your pain level? (0 is no pain and 10 is worst pain) **0 1 2 3 4 5 6 7 8 9 10**

Have you been treated by any other doctor or facility for this problem? YES NO

If yes, please list doctors/facilities treated at: _____

Please list ANY medications tried for this problem, (including over the counter Advil, Aleve, Tylenol, etc.):

_____

Are you currently working? YES NO __Full Duty __Light Duty __Retired __Not Employed

If No, last date of work:_____ Occupation _____

Employer Name: _____ Employer Ph#_____

Is this the result of a Work Injury? YES NO **Is this the result of a Motor Vehicle Accident?** YES NO

Work Injury Claim#:_____ Date of Injury:_____

Do you have Advanced Care Directives? YES NO

If yes, who is your Custodian? _____

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ ACCT# _____

PATIENT'S PAST MEDICAL HISTORY

Do you **currently have or ever had** any of the following conditions?

__Heart Disease/Condition	__High Blood Pressure	__Pacemaker	__High Cholesterol
__History - Blood Clots	__Stroke	__Lung Disease	__ Asthma
__Stomach Disease	__Stomach Ulcers	__Diabetes	__Hypothyroidism
__Post-Menopausal	__Osteoporosis	__Mental Disease	__Depression
__ Anxiety	__Liver Disease	__Kidney Disease	__Wound Healing Problems
__Metal Implants	__Cancer History		

**If any of the above were checked, please explain: _____

_____

**Other medical problems not listed above: _____

Have you ever had an operation for any medical problem? YES NO

Procedure: _____ Date or Year Performed _____

Procedure: _____ Date or Year Performed _____

(**If you have had more than two procedures, please list any additional procedures on the back of this sheet)

FAMILY MEDICAL HISTORY

Do any of your parents or siblings **currently have or ever had** any of the following conditions?

__Heart Disease/Condition	__High Blood Pressure	__Pacemaker	__High Cholesterol
__History - Blood Clots	__Stroke	__Lung Disease	__ Asthma
__Stomach Disease	__Stomach Ulcers	__Diabetes	__Hypothyroidism
__Post-Menopausal	__Osteoporosis	__Mental Disease	__Depression
__ Anxiety	__Liver Disease	__Kidney Disease	__Wound Healing Problems
__Metal Implants	__Cancer History		

LIST OF CURRENT MEDICATIONS:

_____

Do you have any known medication allergies? YES NO (if yes, please list and/or use the back of this sheet)

_____

Do you take blood thinners? (Aspirin, Coumadin, Plavix, Heparin, etc.) YES NO

Do you have a problem taking aspirin? YES NO

Are you allergic to or have you ever had any adverse reaction to:

__ Shellfish __Adhesive __Latex ___None

Do you currently smoke? YES NO If you quit, when:_____ **Do you drink alcohol?** YES NO

Do you use any recreational drugs? YES NO

My last BONE DENSITY was performed on or around: _____

Location/Facility: _____ (Please provide closest date possible)

_____NEVER PERFORMED