PATIENT INFORMATION

Chart # _____ Date _____

Patient's Full Name _____ Sex ☐ Male ☐ Female

Patient's SSN _____ Date of Birth _____ Age _____

Patient's Address _____

City _____ State _____ Zip _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Patient's Phone Home ( ) _____ Work ( ) _____ Cell ( ) _____

Spouse's Name _____ Phone ( ) _____ Cell ( ) _____

Emergency Contact _____ Phone ( ) _____ Cell ( ) _____

Insurance Policy Holder (if different than patient) Is a referral needed? _____

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Relationship to Patient _____

Secondary Insurance Information

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Relationship to Patient _____

Primary Care Physician _____ Phone _____

Referred by _____ Phone _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers concerning the illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself of my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services (ie. Rehab, physical therapy, etc.) to me. If I fail to obtain a referral, I understand that I am financially responsible.

Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION (your signature is required)

Do You Authorize another person to receive your medical information?

☐ No ☐ Yes If yes, who? _____

Do You Authorize us to leave your test results on your answering machine or voice mail?

☐ No ☐ Yes If yes, at which phone number(s)? _____

Signature _____ Date _____

Reason for Visit/Chief Complaint _____

Date Symptoms/Injury Began _____ Work Related Injury _____

Patient's Height _____ Patient's Weight _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Depression			Pneumonia		
Heart Attack			Panic Attack			Asthma		
Heart Murmur			Epilepsy			Tuberculosis		
High Blood Pressure			Reflux (GERD)			Diabetes		
High Cholesterol			Ulcers			Cancer		
DVT or Blood Clots			Hypothyroid			Enlarged Prostate		
Bleeding Tendencies			Kidney Disease			HIV		
Anemia			Kidney Stones			Rheumatoid Arthritis		
Hepatitis - What Type			COPD			Arthritis DJD		
			Emphysema					

PAST SURGICAL HISTORY

Surgeries/Hospitalizations	
1.	5.
2.	6.
3.	7.
4.	8.

Check box if list continues ☐

Have You Ever Had A Problem With Anesthesia? ☐ No ☐ Yes
Explain:_____

Medications/Vitamins/Supplements	Dose	Medications/Vitamins/Supplements	Dose	Medications/Vitamins/Supplements	Dose
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

Check box if list continues ☐

ALLERGIES TO MEDICINE/TYPE OF REACTION

FAMILY HISTORY (Check all that apply.)

☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Osteoporosis ☐ Rhuematoid
☐ Cancer ☐ Back Problems ☐ Anesthesia Problems ☐ Other_____

SOCIAL HISTORY

Tobacco Use: ☐ No ☐ Yes, Packs per day?_____For_____Years ☐ Stopped – When?_____
Daily Alcohol Use: ☐ No ☐ Yes, Amount?
Describe your work demands: ☐ Sedentary ☐ Heavy Labor ☐ In Between
Do you excersize regularly? ☐ No ☐ Yes, Describe routine_____

REVIEW OF SYSTEMS

Symptom	No	Yes		No	Yes
Weight loss			Difficult urination		
Fever and/or chills			Pain or burning on urination		
Fatigue			Blood in urine		
Double vision			Frequent urge to empty bladder		
Loss of vision			Loss of urine when laughing, coughing, etc		
Loss of hearing			Swelling in joints		
Severe nose bleeds			Morning stiffness		
Hoarseness			Weakness		
Frequent sore throats			Frequent itching		
Shortness of breath with exertion			Rashes		
Swelling of feet or ankles			Skin cancer		
Sudden changes in rate of heart beat			Numbness/tingling		
Pain or pressure in chest with exertion			Seizures		
Awakened at night short of breath			Memory loss		
Asthma			Balance problems		
Chronic cough			Do you worry a lot?		
Coughing up blood			Are you a nervous person?		
Rattling or wheezing sounds in chest			Are you frequently unhappy or depressed?		
Frequent chest of bronchial infections			Excessively thirsty, hot, cold, sleepy		
Nausea or vomiting			Loss of energy		
Vomiting of blood			More pale appearance		
Any change in bowel habits			Hay fever		
Blood in or on bowel			Seasonal Allergies		
Use laxatives regularly			Women Only? Are you pregnant?		
Heartburn			Date of your last menstrual period:		