Name: Date:

Patient Information

☐ **New Patient** ☐ **Returning Patient**

Last Name	First Name	Middle Initial

Date of Birth MM/DD/YYYY _____/_____/_____	Sex ☐ Male ☐ Female	Social Security #

Address	City	State	Zip Code

Primary Phone Number ☐ Home ☐ Work ☐ Cell	Secondary Phone Number ☐ Home ☐ Work ☐ Cell	Preferred Contact Method ☐ Phone call ☐ Text ☐ Email

Marital Status	Email	Employment Status
☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated ☐ Partner	To be used for provider communication, follow up, patient portal, and practice related material. We DO NOT share email information with other parties. You may choose to remove at any time.	☐ Full time ☐ Part time ☐ Not employed ☐ Student ☐ Homemaker ☐ Retired

Preferred Language ☐ English ☐ Spanish ☐ Other _____	Employer	Job Title

Race	Preferred Pharmacy:
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Asian ☐ Black or African American ☐ Unreported ☐ Hispanic ☐ White	

Insurance Information

Primary Insurance Company	

Name of Policy Holder ☐ Same as above	Policy Holder's Date of Birth ☐ Same as above ____/_____/_____

Policy Holder's Relationship to Patient ☐ Self ☐ Mother ☐ Father ☐ Other _____	Policy Holder's Social Security # ☐ Same as above

Subscriber Number	Group Number

Secondary Insurance Company ☐ N/A	Name of Policy Holder ☐ Same as above

Secondary Subscriber Number	Secondary Group Number

In Case of Emergency

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following listed individuals:

Name	Relationship	Phone Number	Yes or No

Reason For Today's Visit

Chief Complaint (please describe symptoms)	

☐ Medical Treatment (list symptoms above) ☐ Physical - ☐ School ☐ Work ☐ DOT ☐ Work Related Injury – Worker's Compensation ☐ Pre-op Medical Clearance ☐ Car Accident or Auto Related Injury ☐ Unknown Cause ☐ Home Injury ☐ Other _____	Onset/Injury Date

Name: Date:

Please report previous treatment received for condition

☐ Emergency Room	☐ Prescribed Medication	☐ Surgery	☐ Ice	☐ Other: _____
☐ Physical Therapy	☐ Over-the-counter Medication	☐ Rest	☐ Heat	☐ Other: _____
☐ Massage	☐ Chiropractic Adjustment	☐ Stretching	☐ Bracing	☐ Other: _____

Current Medications Prescribed by Another Provider or anything you are taking over the counter

Medication	Dosage	Condition

Medical History (check all that apply)

☐ ADD/ADHD	☐ Chronic Fatigue Syndrome	☐ Hearing Impairment	☐ Pacemaker
☐ AIDS/HIV	☐ Constipation	☐ Heart Disease	☐ Parkinson's Disease
☐ Allergies	☐ COPD	☐ Heart Murmur	☐ Pinched Nerve
☐ Alzheimer's/Dementia	☐ Depression	☐ Hepatitis	☐ Scoliosis
☐ Anemia	☐ Diabetes: Insulin / Non-insulin	☐ Herniated Disk	☐ Seizure Disorder
☐ Appendicitis	☐ Ear Infections	☐ Herpes/Lesions/Shingles	☐ Sinusitis
☐ Arthritis	☐ Eating Disorder	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Eczema	☐ High Cholesterol	☐ STD
☐ Autoimmune Condition	☐ Eye Problems	☐ Hypoglycemic	☐ Stroke/ TIA
☐ Back Pain	☐ Fainting /Syncope	☐ Influenza/ Pneumonia	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Joint Pain	☐ Tonsillitis
☐ Bronchitis	☐ Fractures	☐ Kidney Disease/ Stones	☐ Tumors/Growths
☐ Cancer: _____	☐ Gallbladder Disorder	☐ Measles/ Mumps/ Rubella	☐ Ulcers
☐ Cataracts	☐ Glaucoma	☐ Miscarriage	☐ Vaginal Infections
☐ Chest Pain	☐ Gout	☐ Mononucleosis	☐ Vertigo
☐ Chicken Pox	☐ Headaches	☐ Osteoporosis	☐ Other:

Allergies

Medication Allergies:	Reaction:
Supplement Allergies:	Reaction:
Food Allergies:	Reaction:
Other:	Reaction:

Name: Date:

Surgical History (check all that apply)

☐ Angioplasty	☐ Debridement	☐ Lumpectomy
☐ Arthroscopy	☐ Dilation and Curettage	☐ Mastectomy
☐ Appendectomy	☐ Ear Tubes	☐ Pacemaker/Defibrillator
☐ Biopsy (site):	☐ Eye Surgery (specify):	☐ Skin Lesion Removal
☐ Bunionectomy	☐ Gallbladder Removal	☐ Spinal Surgery (type):
☐ Cardiac Surgery (type):	☐ Gastric Bypass	☐ Thyroid Surgery
☐ Carpal Tunnel	☐ Hernia	☐ Tonsillectomy
☐ Cesarean Section	☐ Hysterectomy	☐ Tubal Ligation
☐ Colostomy	☐ Joint Replacement	☐ Vasectomy
☐ Cosmetic (type):	☐ Kidney Surgery	☐ Other:
Any hospitalizations besides surgeries?		

Family History Please Circle: Mother: Alive/Deceased Father: Alive/Deceased

Check all that apply. Please indicate family member associated with condition: M-Mother, F- Father, S-Sister, B- Brother, MG- Maternal Grandmother, MF- Maternal Grandfather, MA- Maternal Aunt, MU- Maternal Uncle, PG- Paternal Grandmother, PF- Paternal Grandfather, PA- Paternal Aunt, PU- Paternal Uncle, C- Child

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ ADD/ADHD		☐ Diabetes		☐ Obesity	
☐ Alcoholism/Substance Abuse		☐ Eczema/Psoriasis		☐ Parkinson's Disease	
☐ Alzheimer's/Dementia		☐ Heart Disease		☐ Psychiatric Disorder	
☐ Arthritis		☐ Hemodialysis		☐ Seizure Disorder	
☐ Asthma		☐ Hepatitis		☐ Stomach or GI problems	
☐ Auto Immune Disease (ex: Lupus)		☐ High Blood Pressure		☐ Stroke/TIA	
☐ Cancer (type):		☐ High Cholesterol		☐ Thyroid Problems	
☐ COPD		☐ Kidney Disease		☐ Other:	

Social History

Exercise Habits:

☐ Daily ☐ Minimal
☐ 3-4 x per week ☐ None
☐ 1-2 x per week ☐ None Due to Injury/Illness

Tobacco Use:

☐ Never Smoked ☐ Smokeless Tobacco
☐ Current Smoker ☐ Vaporizer
☐ Former Smoker Amt/Day _____ # of years _____

Alcohol Use:

_____ Drinks Per Week

Caffeine Use:

_____ Cups Per Day

Drug Use:

☐ No history of recreational drug use
☐ Former use of recreational drugs
☐ Current use of recreational drugs

Work Habits: ☐ N/A

Average # of hours per week _____

Mostly- ☐ Sitting ☐ Standing ☐ Walking
Labor- ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy
Environment- ☐ Difficult ☐ Stressful ☐ Relaxed ☐ Enjoyable

Name: Date:

Review of Systems (check all that apply)

CONSTITUTIONAL	ENDOCRINE	HEMATOLOGY/LYMPH	CARDIOVASCULAR
☐ Weight Loss	☐ Loss of Hair	☐ Bruising	☐ Murmur
☐ Fatigue	☐ Heat/Cold Intolerance	☐ Gums Bleed Easily	☐ Chest Pain
☐ Fever			☐ Palpitations
EYES	**GASTROINTESTINAL**	**MUSKULOSKELETAL**	☐ Dizziness
☐ Glasses/Contacts	☐ Heartburn/Reflux	☐ Joint Pain Swelling	☐ Fainting Spells
☐ Eye Pain	☐ Nausea/Vomiting	☐ Stiffness	☐ Shortness of Breath
☐ Double Vision	☐ Constipation	☐ Muscle Pain	☐ Difficulty Lying Flat
☐ Cataracts	☐ Change in bowel movements	☐ Back Pain	☐ Swelling Ankles
EAR, NOSE, THROAT	**GENITOURINARY**	**NEUROLOGICAL**	**ALLERGIC/IMMUNOLOGIC**
☐ Difficulty Hearing	☐ Burning/Frequency	☐ Loss of Strength	☐ Hives
☐ Ringing in the Ears	☐ Night Time	☐ Numbness	☐ Eczema
☐ Vertigo	☐ Blood in Urine	☐ Headaches	☐ Hay Fever
☐ Sinus Trouble	☐ Erectile Dysfunction	☐ Tremors	
☐ Nasal Stiffness	☐ Abnormal Discharge	☐ Memory Loss	
☐ Frequent Sore Throat	☐ Bladder Leakage		
RESPIRATORY	**PSYCHIATRIC**	**SKIN**	
☐ Cough Easy	☐ Anxiety/Depression	☐ Rash/Sores	
☐ Wheezing	☐ Mood Swings	☐ Lesions	
☐ Chills	☐ Difficulty Sleeping	☐ Itching/Burning	

Name: Date:

Medical Information Release Form

(HIPAA Release Form)

This ***Release of Information*** will remain in effect until terminated by me in writing.

Name: _____ Date of Birth: _____

Release of Information

[] I authorize the release of information including the diagnosis, records;

Examination rendered to me and claims information. This information may be released to:

[] Spouse_____

[] Child _____

[] Other _____

[] Information is not to be released to anyone

Messages

Please call [] my home [] my work [] my cell number: _____.

If unable to reach me:

[] you may leave a detailed message

[]please leave a message asking me to return your call

[] _____.

The best time to reach me is (day) _____ between (time) _____.

Signed: _____ Date:__/__/_____

Witness: _____Date:__/__/_____