Today's Date_____

Name_____ DOB_____ Age_____

Address_____City,State,Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ SS#_____

Patient Employer_____Occupation_____

Is your condition? _____Auto related _____Work related Marital Status **S M W D**

Who referred you here?_____ Personal Doctor_____

Please list prescription medication you routinely take.

Name of Medication	What is it for?	Dose and Frequency	When did you start?

Do you have any allergies to medication? ____yes ____no If yes, please list:_____
Have you been hospitalized or had surgery? ____yes ____no If yes, please list surgeries:_____

Do any of the following diseases run in your family? Please indicate Mom(M), Dad(D), Sister(S), Brother(B):

Diabetes	Cancer	Heart Disease	Stroke	Depression	Rheumatoid Arthritis	Lupus
M/D/S/B	M/D/S/B	M/D/S/B	M/D/S/B	M/D/S/B	M/D/S/B	M/D/S/B

Is there any chance you could be pregnant now? ____yes ____no

Height_____ Weight_____ General Health_____ Smoking Status: ___ Current ___ Past ___Never

Race: American Indian Caucasian Asian African American Other_____

Ethnicity: _____ Hispanic _____ Non-Hispanic

For each of the conditions below, please indicate if you have had any of these in the past or present.

Past	Present		Past	Present		Past	Present	
___	___	Headaches	___	___	High Blood Pressure	___	___	Diabetes
___	___	Neck Pain	___	___	Heart Attack	___	___	Excessive Thirst
___	___	Upper Back Pain	___	___	Chest Pains	___	___	Frequent Urination
___	___	Mid Back Pain	___	___	Stroke	___	___	Smoking/Tobacco Use
___	___	Low Back Pain	___	___	Angina	___	___	Drug/Alcohol Dependence
___	___	Shoulder Pain	___	___	Kidney Stones	___	___	Allergies
___	___	Elbow/Upper Arm Pain	___	___	Kidney Disorders	___	___	Depression
___	___	Wrist Pain	___	___	Bladder Infection	___	___	Systemic Lupus
___	___	Hand Pain	___	___	Painful Urination	___	___	Epilepsy
___	___	Hip Pain	___	___	Loss of Bladder Control	___	___	Dermatitis/Eczema/Rash
___	___	Upper Leg Pain	___	___	Prostate Problems	___	___	HIV/AIDS
___	___	Knee Pain	___	___	Abnormal Weight Gain/Loss			
___	___	Ankle/Foot Pain	___	___	Loss of Appetite			**For Females Only:**
___	___	Jaw Pain	___	___	Abdominal Pain	___	___	Birth Control Pills
___	___	Joint Pain/Stiffness	___	___	Ulcer	___	___	Hormone Replacement
___	___	Arthritis	___	___	Hepatitis	___	___	Pregnancy
___	___	Rheumatoid Arthritis	___	___	Liver/Gall Bladder Disorder			
___	___	Cancer	___	___	General Fatigue			
___	___	Tumor	___	___	Muscular Incoordination			
___	___	Asthma	___	___	Visual Disturbances			
___	___	Chronic Sinusitis	___	___	Dizziness			

OFFICE POLICIES

I understand that the information which I have provided on this form is essential to determine my needs and to provide appropriate treatment. If you want electronic access to your patient data, please notify the office manager. If any change occurs in my health, I am to report it as soon as possible. I understand that payment for treatment is expected at the time of service, unless other arrangements are made prior to the start of treatment.

Due to the high cost of multiple billings, a charge of 5%/month will be added to each unpaid bill after 60 days.

Patient, Parent or Guardian Signature_____ Date_____