ABOUT YOU

First Name ____________________ **Middle Name** ____________________

Last Name ____________________

Street Address ____

Line 2 - Apartment Number ____

City ____________________ **State** ___________ **Zip** _______________

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email ____________________________

Date of Birth ____ / ____ / ________ **Gender** ☐ Male ☐ Female

Height _______'_______" **Weight** _______ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____________ **Spouse's Name** ____________________

EMERGENCY CONTACT INFORMATION.

Name ____________________________

Phone ____-____-_____ **Relation To You** ____________________

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name ______________________ **Phone** ____-____-_____

Address Line 1 ____

Address Line 2 ____

City ______________________ **State** __________ **Zip** ______________

ID/Policy Number __________________ **Group Number** ____________________

Insured's Name __________________ **Insured's Date of Birth** ____ / ____ / ________

REFERRAL INFORMATION

Referring Physician __________________ **Contact information.** _______________

Referring Patient __________________

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

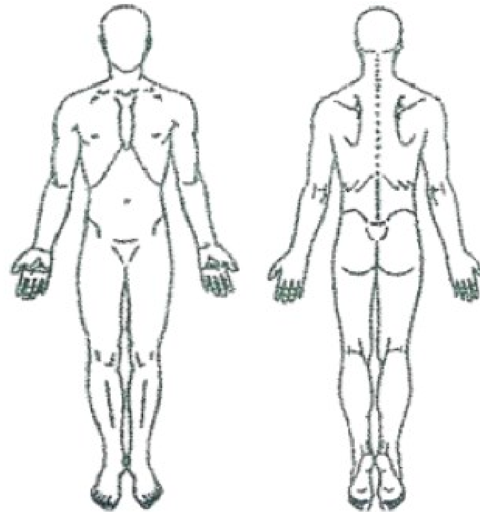
☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment?	____ / ____ / ________
How long have you had this complaint?	☐ Less than 5 days (Acute) ☐ Between 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)
What caused this condition	______________________________
What is the date this condition began? (Skip if due to accident)	____ / ____ / ________
What term(s) describes your discomfort best?	______________________________

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None										*Unbearable*
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort?	☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
How has this complaint changed since the onset?	☐ Worsened ☐ Remained the same ☐ Improved
What activity is most significantly affected by this discomfort? (Explain)	______________________________ ______________________________
What treatment, if any, have you received since the accident?	______________________________ ______________________________

What aggravates this condition? ____

What improves this condition or gives you relief? ____

Have other health care provider(s) performed tests related to this condition? ____
____

Have you ever had any previous episodes of this condition? ____
____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No ☐ Yes	**Explain:** ______________________
Nerves, Headaches, Dizziness, or Emotional	☐ No ☐ Yes	**Explain:** ______________________
Head, Eyes, Ears, Nose or Throat	☐ No ☐ Yes	**Explain:** ______________________
Heart, Blood Pressure, or Circulation	☐ No ☐ Yes	**Explain:** ______________________
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No ☐ Yes	**Explain:** ______________________
Stomach, Bowels or Digestive Conditions	☐ No ☐ Yes	**Explain:** ______________________
Genital, Bladder, or Urinary Conditions	☐ No ☐ Yes	**Explain:** ______________________
Diabetes, Thyroid or Glandular Conditions	☐ No ☐ Yes	**Explain:** ______________________
Skin or Bleeding Conditions	☐ No ☐ Yes	**Explain:** ______________________
Allergies or Sensitivities	☐ No ☐ Yes	**Explain:** ______________________

PERSONAL AND FAMILY HISTORY

Question	Answer
Have you had any surgical procedures?	☐ No ☐ Yes **Explain:** ____________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes **Explain:** ____________
Do you have a past history of accidents or trauma?	☐ No ☐ Yes **Explain:** ____________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes **Explain:** ____________
Are you presently taking any medication?	☐ No ☐ Yes **Explain:** ____________
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	☐ No ☐ Yes **Explain:** ____________

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH

Question	Answer
Do you have pain or lump in scrotum or testicles?	☐ Yes ☐ No
Do you have an impaired libido (sex drive)?	☐ Yes ☐ No
Do you have discharge from your penis?	☐ Yes ☐ No
Do you have prostate issues?	☐ Yes ☐ No
When was your last prostate exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a prostate exam ☐ Prefers not to answer or don't know
When was your most recent PSA (Prostate-Specific Antigen) blood test?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PSA blood test ☐ Prefers not to answer or don't know
What was your PSA (Prostate-Specific Antigen) level on your latest test?	☐ Normal or low ☐ Moderate ☐ High ☐ Never had a PSA level done ☐ Prefers not to answer or don't know

WOMEN'S HEALTH

Question	Answer
Are you pregnant?	◻ Yes ◻ No
Are you nursing?	◻ Yes ◻ No
Are you taking birth control?	◻ Yes ◻ No
Do you experience painful periods?	◻ Yes ◻ No
Do you have irregular cycles?	◻ Yes ◻ No
Do you have breast implants?	◻ Yes ◻ No
Do you perform a regular self-breast examination?	◻ Yes ◻ No
Do you take hormone replacement therapy (HRT)?	◻ Yes ◻ No
Do you take oral contraceptives?	◻ Yes ◻ No
When was your last PAP/pelvic exam?	◻ Within the past year ◻ Between 1-4 years ◻ Greater than 5 years ◻ Never had a PAP or pelvic exam ◻ Prefers not to answer or don't know
	◻ Within the past year ◻ Between 1-4 years ◻ Greater than 5 years ◻ Never had a mammogram exam ◻ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	◻ Within the past month or currently ◻ Within the past 1-3 months ◻ Greater than 3 months ◻ Postmenopausal ◻ Have not yet begun menstruation ◻ Prefers not to answer or don't know