NEW PATIENT INFORMATION

Name: ______________________

D.O.B.: ______________________

S.S. #: ______________________

Age: ______________________

Gender: ☐ Male ☐ Female

Referred here by: (check one)

_______ Self _______ Family _______ Friend _______ Doctor _______ Other Health Professional _______ Attorney

Name of person making referral ______________________

Who is your primary care physician (family physician)? ______________________

Please describe the reason for your visit today?

____

____

____

Is this problem: Resulting from Accident ☐ Yes ☐ No   Work Related ☐ Yes ☐ No   Involving Litigation ☐ Yes ☐ No

Date symptoms began (approximate) ______________________

Please describe any previous treatment for this problem and results (include physical therapy, surgery and injections):

____

PAST SURGICAL HISTORY

Previous Operations:

Type; Approximate Year

1) ______________________

2) ______________________

3) ______________________

4) ______________________

Any Previous Fractures? ☐ Yes ☐ No   Describe ______________________

Any other serious injuries? ☐ Yes ☐ No   Describe ______________________

MEDICATIONS:

DRUG ALLERGIES: ______________________

Type of reaction ______________________

Are you allergic to any foods? ☐ Yes ☐ No   If yes, please list ______________________

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

MEDICAL HISTORY / REVIEW OF SYSTEMS

Please check if you have had a history of any of the following:	YES	NO		YES	NO
GENERAL			**NEUROLOGICAL**		
Are you currently pregnant?			Headaches		
Diabetes			Dizziness		
Stroke			Fainting		
Kidney disease			Memory loss		
Ulcers			Loss of consciousness		
Asthma or Lung Disease			Muscle spasm		
Cancer TYPE:			Numbness or tingling of hands/feet		
Fatigue			Blindness or trouble seeing		
Weakness			Deafness or trouble hearing		
Fevers					
Skin problems/disorders TYPE:			**HEMATOLOGIC**		
Gout			Anemia		
Phlebitis			Blood clots		
Rheumatic fever			Bleeding tendency		
Tuberculosis			Easily bruised		
			Circulatory problems		
CARDIOVASCULAR			Bloodthinners (currently on)		
Chest pain, Angina			(if yes, type?________________)		
Heart Attack, Myocardial Infarction					
Palpitations			**MUSCULOSKELETAL**		
High Blood Pressure, Hypertension			Joint pain		
Shortness of breath			Joint swelling		
Ankle swelling			Muscle weakness		
			Muscle tenderness		
			Morning stiffness		
			Arthritis/Osteoarthritis		
			Rheumatoid Arthritis		
			Bunions		
			Osteoporosis		
			Bone/Joint infections		

Other illnesses or diseases which are not listed? Please describe

SOCIAL HISTORY

What is your approximate weight? Lbs. Height? Ft. In.

Occupation No. of Years Job Duties

Do you smoke? ☐ Yes ☐ No ☐ Past If yes, amount:

Are you ☐ right handed ☐ left handed

Do you drink alcohol? ☐ Yes ☐ No How much How often

Have you ever had a problem with drugs? ☐ Yes ☐ No

Please list all sports and hobbies you are involved in:

I have reviewed this information with this patient. Date: M.D. signature:

INFORMATION UPDATED