NEW PATIENT INFORMATION

(Office Use Only)

DX: CODE/S: _____

ONSET: _____REFERRING DR: _____PCP: _____

NEXT DR APPT: _____

PATIENT'S NAME: _____DATE OF BIRTH: ____/____/_____ SEX: M F

HOME ADDRESS: _____

CITY, STATE, ZIP:_____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE:_____

EMAIL ADDRESS:_____

SOCIAL SECURITY #: _____MARITAL STATUS: S M W D

OCCUPATION:_____DATE OF ONSET/INJURY_____

HOW DID IT HAPPEN? _____

PRESENT COMPLAINT:_____

HAVE YOU RECEIVED ANY PHYSICAL, OCCUPATIONAL, SPEECH THERAPY OR CHIROPRACTIC TREATMENT IN THE PAST 12 MONTHS?_____

REASON FOR CHOOSING THIS FACILITY: _____

LIST TWO PEOPLE TO CONTACT IN CASE OF AN EMERGENCY:

1._____ PHONE: _____

2._____ PHONE : _____

MEDICAL INFORMATION: Do you have or have a history of: Mark all that apply:

( ) Allergies ( ) Anemia ( ) Angina ( ) Anorexia/Bulimia ( ) Arthritis ( ) Asthma ( ) Alcohol/Drug Abuse ( ) Back/neck injury ( ) Blood clots ( ) Blood disorder or disease ( ) Cancer ( ) Circulatory problems ( ) Diabetes ( ) Depression/Anxiety ( ) Epilepsy/Seizures ( ) Emphysema ( ) Fibromyalgia ( ) Gastrointestinal problems ( ) Headaches/Migraine ( ) HIV/Hepatitis ( ) Hearing loss ( ) Heart attack ( ) High BP ( ) High Cholesterol ( ) Heart disease/CHF ( ) Hypoglycemia ( ) Kidney Issues ( ) Lyme disease ( ) Liver disease ( ) Osteoporosis/Osteopenia ( ) Pacemaker ( ) Parkinson's Disease ( ) Polio ( )Rheumatic fever ( ) Stroke ( ) Thyroid problems ( ) Other_____

Do you smoke or use tobacco? Y/N Do you have a history of falling? Y/N # falls past year____ Do you consume 3 or more alcoholic beverages /day? Y/N Females, is there a possibility you may be pregnant? Yes/No

Are you experiencing any of the following symptoms: ( ) Fever/chills/sweats ( ) Unexplained weight loss ( ) Motion sickness ( ) Change in bowel/bladder habits ( ) Shortness of breath ( ) Unusual weakness/fatigue

Surgical history:_____

Are you having difficulty with: ( ) Dressing ( ) Bathing ( ) Grooming ( )Toileting ( ) Walking ( ) Eating

Are you taking? ( ) BP meds ( ) Insulin ( ) Blood thinners ( ) Steroids ( ) Antibiotics ( ) Breathing meds ( ) Calcium supplement ( ) Vitamin D supplement ( ) Opioids (hydrocodone, oxycodone, morphine, codeine, etc) Please provide a list of all Medication/Supplements you are on including dose and frequency:_____

_____

_____

Height ___ft___inches Weight ____lbs Dominant arm: R/L