Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**PATIENT INFORMATION**

 Name: (First MI Last) \_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female Height & Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Emergency Contact Name: Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 **FINANCIAL INFORMATION**

\*\*If you are here for the “No Cost Consult”, to continue care we will need insurance information, you may provide it after your appointment.

Will we be working with insurance? Yes No

 Primary Ins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the Primary Insurance Holder? Yes No

If No. Name and DOB of Insurance holder (Primary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where would you like statements sent?

 Self Other (Details below)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen them within the last 12 months? Yes No

**HISTORY OF PRESENT ILLNESS**

HISTORY OF PRESENT ILLNESS (IF extremities please define **Left, Right or Both**)

Major Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Complaint: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it start? \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Describe what happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which daily activities are being affected by this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MAJOR COMPLAINT***
Information and Previous Treatments
(Please check all that apply)

**Grade Intensity/Severity**:

* None (0/10)
* Mild (1-2/10)
* Mild-Moderate (2-4/10)
* Moderate (4-6/10)
* Moderate-Severe (6-8/10)
* Severe (8-10/10)

 **Frequency:**

* Off & On
* Constant

**Quality**:

* Sharp
* Stabbing
* Burning
* Achy
* Dull
* Stiff & Sore **Improves with:**
* Ice
* Heat
* Movement
* Stretching
* OTC Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Worsens with:**

* Sitting
* Standing/Walking
* Lying Down/Sleeping
* Overuse/Lifting
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatment:**

* None
* Chiropractor
* Physical Therapy
* Medical Doctor
* ER/Urgent Care
* Orthopedic
* Other (including injections): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Diagnostic Testing**:

* None
* X-rays
* MRI
* CT
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST AND SOCIAL HISTORY**

***PAST MEDICAL HISTORY*** Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

* **Injuries**:
* Back Injury
* Broken Bones
* Head Injury
* Neck Injury
* **Falls: How often? \_\_\_\_\_\_\_\_\_**
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Illnesses**:

* Asthma
* Autoimmune Disorder (Type) \_\_\_\_\_\_\_\_\_\_\_
* Blood Clots
* Cancer (Type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CVA/TIA (stroke)
* Diabetes
* Migraine Headaches
* Osteoporosis

**Are you currently:**

* On blood thinners (aspirin, coumadin, warfarin)
* On antibiotics
* Anemic
* Struggling with hepatitis
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food or Medical Allergies:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY AND CURRENT MEDICATIONS** (Please provide as much information as possible)

**Surgeries**: (If yes, provide type & surgery date)

* Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Orthopedic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Shoulder – R / L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Elbow/Forearm – R / L \_\_\_\_\_\_\_\_\_\_\_\_
* Wrist/Hand – R / L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hip – R / L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Knee – R / L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Ankle/Foot – R / L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Spinal Surgery \_\_
* Neck: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Back: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (Tonsils, Gallbladder, any childhood surgeries, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current Medications including Over the Counter Medication: *If you have a list, please give it to the front desk to make a copy.***

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Hospitalizations: (Non-surgical with Date):** ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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