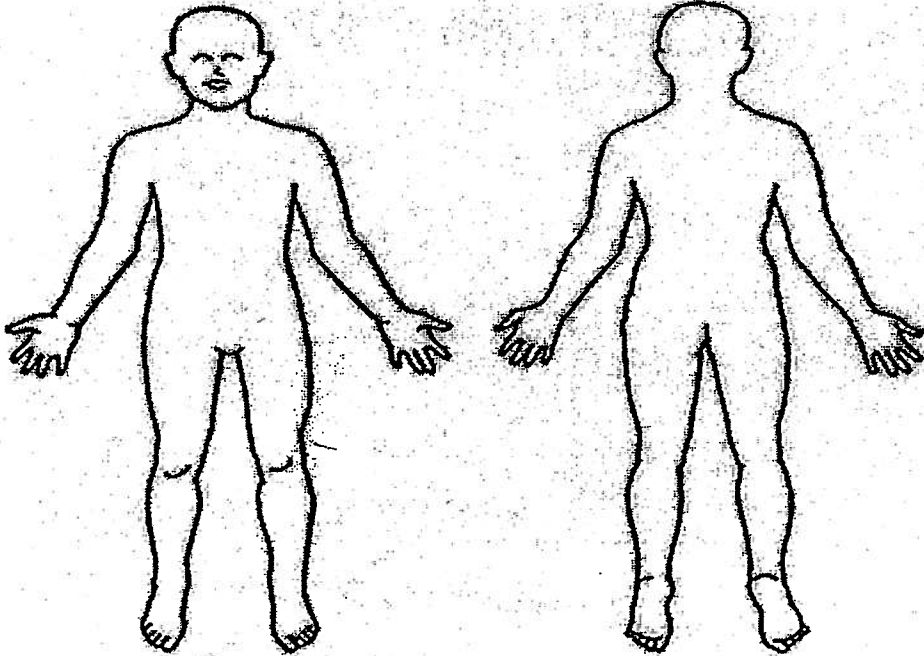


<b>1</b>	<b>PATIENT INFORMATION</b>		
Patient Name: (Please Print) Last: _____ First: _____ Middle: _____ Social Security Number: _____ Address: _____ _____ (Street & Apt #) (City) (State) (Zip code) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ Primary Phone: _____ Secondary Phone: _____			
<b>2</b>	<b>PARENT/GUARDIAN INFORMATION (If Applicable)</b>		<b>3</b>
Name: _____ Relationship: _____ Address: _____ City/State: _____		Name: _____ Address: _____ City/State: _____	
<b>4</b>	<b>PRIMARY INSURANCE COMPANY</b>		<b>5</b>
Name: _____ PN#: _____ Address: _____ (Street) (City) (State) (Zip)		Name: _____ PN#: _____ Address: _____ (Street) (City) (State) (Zip)	
<b>6</b>	<b>WORKMEN'S COMPENSATION</b>		
Company Name: _____ Case Number: _____ Date of Injury: _____ Address: _____ Case Manager: _____ Phone: _____			
<b>7</b>	<b>EMERGENCY CONTACT INFORMATION</b>		
Name: _____ Relationship: _____ Phone Number: _____			
<b>8</b>	<b>ALLERGY INFORMATION (Please List e.g. medications, latex, tape, shellfish, iodine, peanuts, etc.)</b>		
Drug Allergies: _____ Other Allergies: _____			
<b>9</b>	<b>Family History (Check all that apply)</b>		
<input type="checkbox"/> Alcohol/Drug Abuse _____ <input type="checkbox"/> Death before 50 _____ <input type="checkbox"/> Elevated cholesterol _____ <input type="checkbox"/> HTN/Stroke _____ <input type="checkbox"/> Cancer/ Type _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Heart disease _____ <input type="checkbox"/> Mental illness _____ <input type="checkbox"/> Other _____			
Brief explanation of any marked history _____			
<b>10</b>	<b>MEDICAL HISTORY</b>		
Do you have a present or past history of: (check all that apply)			
<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Cough (chronic) <input type="checkbox"/> Heart Disease/Problems <input type="checkbox"/> Sexually Transmitted Infections <input type="checkbox"/> Allergies (e.g. hayfever) <input type="checkbox"/> Depression <input type="checkbox"/> Hepatitis/Jaundice <input type="checkbox"/> Sickle Cell Trait/Anemia <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Hernia/Rupture <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Arthritis <input type="checkbox"/> Disability/Handicap <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Skin Problems; rashes, lesions, etc. <input type="checkbox"/> Asthma <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Intestinal/Stomach Trouble <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Back Problems <input type="checkbox"/> Ear Trouble/Hearing Loss <input type="checkbox"/> Joint Disease/Injury <input type="checkbox"/> Spleen, Surgical Removal <input type="checkbox"/> Bladder/Bowel Problems <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Eye Disease/ Problems <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> Gallbladder Trouble <input type="checkbox"/> Pneumonia <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> COPD <input type="checkbox"/> Head Injury <input type="checkbox"/> Paralysis <input type="checkbox"/> Weight Loss (unexplained) <input type="checkbox"/> Cough (Chronic) <input type="checkbox"/> Headache (Recurrent) <input type="checkbox"/> Psychological Counseling <input type="checkbox"/> Other			
Brief explanation of any marked medical history _____			
<b>11</b>	<b>MEDICATION HISTORY (PRESCRIPTION, BIRTH CONTROL, OVER THE COUNTER, HERBAL)</b>		
<b>12</b>	<b>SURGICAL HISTORY (Include dates)</b>		
<b>13</b>	<b>SOCIAL HISTORY</b>		

<b>13</b>	<b>SOCIAL HISTORY</b>	
	Marital Statuses: S M D W P	Occupation: _____
	Do you use?: Caffeine N Y _____ cups per day	
	Tobacco N Y _____ packs per day	
	Alcohol N Y _____ oz. per day	
	Street Drugs N Y _____ type, frequency	
<b>14</b>	<b>MILITARY SERVICE</b>	
	Branch: _____	Conflict: _____
	1. Were you a POW? N Y	2. Did you see combat or enemy fire? N Y
	3. Were you wounded or injured? N Y	4. Were you exposed to any hazardous materials N Y
	5. Do you suffer from Post Traumatic Stress Disorder? N Y	
<b>15</b>	<b>PAIN ASSESSMENT</b>	
	Have you sustained any musculo-skeletal injuries (e.g. sprain, strain, fracture, dislocation) to the following areas:	
	Neck N Y	Shoulder N Y
	Elbow N Y	Hip/Pelvis N Y
	Wrist N Y	Hand/Finger N Y
	Back N Y	Quad/Hamstring N Y
	Calf/Shin N Y	Ankle N Y
	Foot N Y	Knee N Y
<b>16</b>	Please indicate by drawing line where you are having pain.	
		
	I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made.	
	_____	_____
	Patient Signature	Date
	_____	_____
	Reviewed by Nurse/Other	Date
	_____	_____
	Reviewed by Physician	Date