Patient Information

Patient Name: _____ **D.O.B** _____

Address _____**City** _____ **State** _____ **Zip** _____

Home Phone (_____**)** _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____**)** _____-_____ **Circle One:** Male / Female

Emergency Contact _____ **Phone (**_____**)** _____-_____

Email Address _____

How did you hear about us? (i.e.: Doctor, Friend, Ad, Other**)** _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

We use automated reminders to confirm your appointments. Circle your preferred form of contact? phone / text / email

Occupation _____ Employer_____

Work Address _____ City _____ State _____ Zip _____

***Responsible Party Information** (if applicable)*

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Guarantor Name: _____ Date of Birth _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Primary Insurance Information

Carrier's Name _____ **Phone (**_____**)** _____-_____

Policy/I.D. #: _____ **Group #** _____

Address _____ City _____ State _____ Zip _____

Authorization/Referral #:_____

Secondary Insurance Information

Carrier's Name _____ **Phone (**_____**)** _____-_____

Policy/I.D. #: _____ _____**Group #**_____

Health History Information

Patient Name _____ _____ _____

(Last) **(First)** **(M.I.)**

Injury_____ **Date of Onset**_____/_____/_____

Briefly describe previous treatment, if any: _____

_____

Do you have now, or have you ever had, any of the following?

Diabetes	Yes____ No____	Allergy or Cold	Yes____ No____
High Blood Pressure	Yes____ No____	Other Allergies	Yes____ No____
Pacemaker	Yes____ No____	Previous Surgery	Yes____ No____
Chronic Headaches	Yes____ No____	Seizures	Yes____ No____
Kidney Problems	Yes____ No____	Metal Implants	Yes____ No____
Nervous Disorders	Yes____ No____	Dizziness	Yes____ No____
Hernia	Yes____ No____	Cancer	Yes____ No____
Allergy to Heat	Yes____ No____	Pregnant	Yes____ No____
Bone Disease	Yes____ No____	Osteoporosis	Yes____ No____
Fractures	Yes____ No____	Bowel Problems	Yes____ No____
Bladder Problems	Yes____ No____	Recent Weight Loss	Yes____ No____
Pins & Needles	Yes____ No____	Circulatory Disease	Yes____ No____
Problems with Both Arms or Both Legs at the Same Time			Yes____ No____

If you answered YES to any of the above, please describe briefly and provide appropriate details:

_____

_____

Are you presently taking any medications? **Yes____ No____**

If you answered YES, please list your medications and for what condition: _____

_____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic test for your current injury?

Yes____ No____

If you answered YES, please explain the findings as you understand them: _____

_____