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NEW PATIENT ENTRANCE AND HISTORY FORM

How did you hear about us? Friend/Family Website
Ad: Other:

Please Print

PATIENT INFORMATION

Today's Date: Sex: Female Male

Name FIRST MI LAST Social Security #

Race/Ethnicity Preferred Language

Address City State Zip

Email Address May we contact you or send information via email? Yes No

Home Phone Cell Phone Work Phone

At which phone(s) do you prefer to receive calls? Home Cell Work

Birthdate Age Are you: Minor Married Divorced Widowed Single Separated

Employer Occupation

Address City State Zip

Spouse's/Parent's Name

Employer Work Phone

Emergency Contact Relationship

Home Phone Cell Phone Work Phone

Payment Method: Self-pay Other Insurance

Name of Policy Holder Birthdate of Policy Holder

WOMEN ONLY

Date of last menstrual period Are you pregnant? No Yes; Due date

Nursing? No Yes Taking birth control pills/patches? No Yes

DAILY HABITS

What type of exercise do you perform on a regular basis? None Physical Job:

Workout Regularly; Type: In Training for Athletics:

Daily work habits include? Sitting Standing Light Labor Heavy Labor Computer Work Other:

Do you currently Smoke? No Yes; Per day? Did you Smoke? No Yes; Date stopped:

Do you drink Alcoholic Beverages? No Yes; Per week?

DAILY HABITS CONT.

Name _____ (pg 2 of 2)

Do you drink Coffee or Caffeinated beverages? No Yes How much per day? _____

Do you drink water (bottled/filtered/plain)? No Yes How much per day? _____

Do you take daily/multiple vitamins? No Yes Brand/Type: _____

List all medications you are currently taking.

Medication	Dosage	Reason for the Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TREATMENTS & DOCTORS

What treatment have you already received for your condition? Medication Surgery Physical Therapy
 Other: _____

Name and Address of other Doctors who have treated you for your condition.

Doctor	Address	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any surgeries which you have had.

Type of Surgery	Date of Surgery	Doctor/Place of Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any Allergies you have.

HEALTH HISTORY

Please all symptoms or conditions you have ever experienced

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Sacroiliac Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Fractures | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Colic | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Polio | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Problems Urinating | _____ |