WELCOME

1 One...

ABOUT YOU

Today's Date_____/_____/_____ File #_____

Name:_____

What You Prefer to be Called_____ □ Male □ Female

Birth date: ____/____/____ Age: ____ S.S.#_____

Home Address:_____

_____

City State Zip

Home Phone#_____

Cell Phone # _____

e-mail address:_____

Referred By:_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name:_____

Your Employer:_____

Employer's Address:_____

_____

Occupation:_____ Work Phone #:_____

2 Two...

INSURANCE INFO

Co. Name:_____

Address:_____

Phone #:_____

Insured's SS #:_____

Group #:_____

Insured's Name:_____

Relation:_____Date of Birth___/___/__

Insured's Employer:_____

REASON FOR VISIT

Please describe major complaint:_____

Please describe type of pain: (achy/sore/burning…)_____

Please describe exact location of pain:_____

Is this visit a result of (*Please circle*): work, sports or auto accident, other trauma or chronic.

When did you first notice this? ____/____/____.

Have you been treated by a Medical Physician for this condition? □ Yes □ No

If yes, by whom?_____

Have you had this or similar condition in the past? □ Yes □ No

If yes, how was it treated?_____

Is this condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is this condition interfering with your (Please Circle): work, sleep or daily routine?

On the line below, please circle the severity of your pain. (1 = none, 10 = extreme)

_____

1 2 3 4 5 6 7 8 9 10

3 Three...

Please continue on back

4 Four...

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

HEALTH HISTORY

Are you taking any of the following medications?

□ Nerve Pills □ Pain Killers (including aspirin) □ Muscle relaxers □ 'Pep" pills
□ Blood thinners □ Tranquilizers □ Insulin □ Other(s)_____

5 Five...

Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack/Stroke	Y N Heart Surg/Pacemaker	Y N Heart Murmer
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/ AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus problems	Y N Asthma
Y N Diabetes/ Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to:_____

_____

List previous surgeries/treatments with dates:_____

_____

List any **past** serious accidents with dates:_____

_____

Do you smoke? □ No □ Yes/ How much?_____ How long?_____

Are you wearing:□ Heel lift □ Sole lift □ Inner soles □ Arch supports

What is the age of your mattress?____ Is it comfortable? □ No □ Yes

For Women: Are you taking Birth Control? □ No □ Yes

Are you pregnant? □ No □ Yes/How long?_____ Nursing? □ No □ Yes

6 Six...

Would you like to receive our monthly health newsletter? □ No □ Yes

Would you like to receive our monthly health e-mail? □ No □ Yes