

Patient Basic Information

***NOTE: Please Fill This Out as Thoroughly and NEATLY as Possible, as This Information Is Needed to Properly Process Your Insurance Claim or to Complete Your Computer Data File**

Today's Date:	Date of Injury/Onset:	Patient No. (do NOT fill out)
Last Name:	First Name:	Middle Initial:
Address:	City, State, Zip	
Home Phone:	Cell Phone:	Work Phone:
Email:		Last 4 digits of SS#
Date of Birth:	Age:	Date of First treatment
Notification Preference: Appointment Reminders	Please pick one: <input type="checkbox"/> Text Msg. (90 min prior to appt) <input type="checkbox"/> Call Cell or <input type="checkbox"/> Call Home (24 hours prior to appt) <input type="checkbox"/> Email (48 hours prior to appt)	
Occupation (describe briefly what you do):		
Employer Name and Address:		
Work Activities Include: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Other _____		
How did you hear about us? <input type="checkbox"/> Family/Friend/Co-Worker _____ <input type="checkbox"/> Internet (<input type="checkbox"/> Website <input type="checkbox"/> Google) <input type="checkbox"/> Yellowpages <input type="checkbox"/> Provider List <input type="checkbox"/> Doctor <input type="checkbox"/> Live/Work Nearby <input type="checkbox"/> Sign <input type="checkbox"/> Other _____		
<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time Student Where:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Spouse's/Significant Other's (SO) name:	Spouse's/SO Occupation:	
Emergency Contact Information:		
Name: _____		Relationship: _____
Hm Phone: _____		Cell Phone: _____
Wk Phone: _____		
Days of Work Missed related to this Injury/Condition: _____ days	Date returned to work? _____ <input type="checkbox"/> Not yet back to work	Returned at: <input type="checkbox"/> Light Duty <input type="checkbox"/> Modified Duty <input type="checkbox"/> Regular Duty

Treatment History: Fill in any treatment for this condition/injury) prior to your 1st visit to this office.

1. Dr. _____ First visit date: ___/___/___ Specialty: _____

X-rays done? Yes No Body parts X-rayed? _____

The X-rays revealed: _____

Types of treatments received: _____

Was lab work done? Yes No What lab work? _____

How many treatments received? ___ Currently treating? Yes No Last visit date: ___/___/___

Past Medications from this incident: _____

Follow-up instructions: _____

2. Dr. _____ First visit date: ___/___/___ Specialty: _____

X-rays done? Yes No Body parts X-rayed? _____

The X-rays revealed: _____

Types of treatments received: _____

Was lab work done? Yes No What lab work? _____

How many treatments received? ___ Currently treating? Yes No Last visit date: ___/___/___

Past Medications from this incident: _____

Follow-up instructions: _____

3. Dr. _____ First visit date: ___/___/___ Specialty: _____

X-rays done? Yes No Body parts X-rayed? _____

The X-rays revealed: _____

Types of treatments received: _____

Was lab work done? Yes No What lab work? _____

How many treatments received? ___ Currently treating? Yes No Last visit date: ___/___/___

Past Medications from this incident: _____

Follow-up instructions: _____

INSURANCE INFORMATION

Type of Insurance:

Health Insurance Your Auto Insurance (PIP, UM, UM) 3rd Party Responsible

My Health Insurance Company _____ Insured ID Number _____

Claim Address: _____ City _____ State ___ Zip _____

Phone () _____ FAX () _____ Claim No. _____

My Auto Insurance Company _____ Adjuster's Name _____

Claim Address: _____ City _____ State ___ Zip _____

Phone () _____ FAX () _____ Claim No. _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth _____

3RD PARTY'S Insurance Company _____ Adjuster's Name _____

Claim Address: _____ City _____ State ___ Zip _____

Phone () _____ FAX () _____ Claim No. _____

Review of Systems

Patient Name: _____

Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you have now or have experienced in the past:

CONSTITUTIONAL

- Deny All
- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

EYES

- Deny All
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Dry Eyes
- Eye Pain
- Field Cuts
- Glaucoma
- Sensitivity to Light
- Tearing
- Wears Glasses

CARDIOVASCULAR

- Deny All
- Angina
- Chest Pain
- Claudication
- Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

RESPIRATORY

- Deny All
- Asthma
- Bronchitis
- Dry Cough
- Productive Cough
- Coughing up Blood
- Difficulty Breathing
- Difficulty Sleeping
- Hemoptysis
- Pneumonia
- Sputum Production
- Wheezing

MUSCULOSKELETAL

- Deny All
- Arthritis
- Neck Pain
- Decreased Motion
- Gout
- Injuries
- Joint Pain
- Joint Stiffness
- Locking Joints
- Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- Muscle Weakness
- Swelling

INTEGUMENTARY

- Deny All
- Breast Lumps / Pain
- Change in Nail Texture
- Change in Skin Color
- Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin Lesions

GASTROINTESTINAL

- Deny All
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaunice
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

GENITOURINARY

- Deny All
- Birth Control Therapy
- Burning Urination
- Cramps
- Erectile Dysfunction
- Frequent Urination
- Hesitancy/ Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder Control
- Prostate Problems
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

ENMT

- Deny All
- Bad Breath
- Dentures
- Deviated Septum
- Difficulty Swallowing
- Discharge
- Dry Mouth
- Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Sinus Infections
- Runny Nose
- Snoring
- Sore Throat
- Ringing in Ears
- TMJ Problems
- Ulcers

NEUROLOGICAL

- Deny All
- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- Imbalance
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Deny All
- Agitation
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Homicidal Indication
- Insomnia
- Location Disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

ENDOCRINE

- Deny All
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

HEMATOLOGIC/LYMPHATIC

- Deny All
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusions
- Bruise Easily
- Lymph Node Swelling

ALLERGIC/ IMMUNOLOGIC

- Deny All
- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance