

Date: _____ Name: _____ Soc Sec # _____
Home Phone: _____ Emergency #: _____ Cell Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Race: _____ Marital: M S W D How Many Children? _____
Occupation: _____ Employer: _____
Employers Address: _____ Office Phone: _____
Spouse: _____ Occupation: _____ Employer: _____
How were you referred to our office? _____ Family Medical Doctor: _____
Primary Insurance: _____ Secondary Insurance: _____

Medical History:

1. What medications or drugs are you taking? _____

2. Have you been treated for any health condition by a physician in the past year? NO YES If yes, what? _____
3. Have you been treated by any other physician for your current condition? NO YES If yes, Dr. _____
4. Have you ever had any broken bones? NO YES If yes, please list _____
5. Have you had any major accidents? NO YES If yes, what types? _____
6. Women Only: Are you pregnant or is there any possibility you may be pregnant? NO YES UNCERTAIN
7. To your knowledge, have you had any diseases, major illnesses, or injuries not already indicated on this form? NO YES
If yes, please list and give dates diagnosed: _____

8. Do you have any allergies? NO YES If yes, please list: _____

Family History:

1. To your knowledge, has anyone in your close family had any major illnesses or diseases? NO YES
If yes, please list and give dates diagnosed: _____

Social History:

1. Do you use alcohol? NO YES Amount: _____ Frequency: _____ Year stopped (if applies) _____
2. Do you use tobacco? NO YES Amount/Day: _____ Type: _____ Year stopped (if applies) _____
3. Do you use drugs? NO YES Type: _____ Frequency: _____ Year stopped (if applies) _____