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) _________