Facility:

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Patient Name_____Date_____
First Middle Last Nickname

Address_____ City_____ State____ Zip Code _____

SS# _____ □ Male □ Female Marital Status_____

Spouse's Name_____ Spouse's Employer _____Spouse's Occupation_____

Patient DOB_____ Home Phone_____Mobile Phone _____ Work Phone _____

Email address:_____

Who or What referred you to our office?_____

Patient's Employer _____ Address _____ Occupation_____

In Case of Emergency contact: Name_____Relationship _____Phone_____

INSURANCE INFORMATION:

Present insurance card to front desk for photocopy

MAJOR COMPLAINT/PROBLEM_____

_____

When did your symptoms start?_____ Have you ever had an: Accident? (mo/yr)_____Work injury? (mo/yr)_____

Mark how often you experience your symptoms:	**Mark what best describes your symptoms:**
□ Constantly (76-100% of a day) □ Frequently (51-75% of a day) □ Occasionally (26-50% of a day) □ Intermittently (0-25% of a day)	□ Sharp □ Dull Ache □ Numb □ Shooting □ Burning □ Tingling □ Other:_____

Indicate how your symptoms affect your ability to perform daily activities?

□ No Complaints	□ Mild, forgotten with activity	□ Moderate, interferes with activity	□ Limiting, prevents full activity	□ Intense, preoccupied with seeking relief	□ Severe, no activity possible

Who is your Primary Care Physician?_____ Address _____Phone_____

Who have you seen for your symptoms? _____When and treatment?_____

What tests have you had performed for your symptoms: □ Xrays □ MRI □ CT Scan □ Other_____

Have you had similar symptoms in the past: □ No □ Yes Date_____Did you receive treatment?___

List all surgical procedures you have had and times you have been hospitalized:

_____

_____

List all prescription, over-the-counter medications and nutritional/herbs supplements you are currently taking:

_____

(Please turn over…continued on other side)

(Continued from Reverse Side)

Hist/Phys

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE – Page II

Patient Name_____Date_____

HEALTH HISTORY

If you presently have a condition listed below, place a check in box:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow/Upper Arm Pain
- ☐ Wrist Pain
- ☐ Hand Pain
- ☐ Hip/Upper Leg Pain
- ☐ Knee/Lower Leg Pain
- ☐ Ankle/Foot Pain
- ☐ Jaw Pain
- ☐ Joint Swelling/Stiffness
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ General Fatigue
- ☐ Muscular Incoordination
- ☐ Visual Disturbances
- ☐ Dizziness
- ☐ Balance difficulties
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pains
- ☐ Stroke
- ☐ Angina
- ☐ Kidney Stones
- ☐ Kidney Disorders
- ☐ Bladder Infection
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Prostate Problems
- ☐ Abnormal Weight gain/Loss
- ☐ Loss of Appetite
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Liver/Gall Bladder Disorder
- ☐ Stomach Disorder
- ☐ Cancer
- ☐ Tumor
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Use Tobacco Products
- ☐ Drug/Alcohol Dependence
- ☐ Allergies
- ☐ Depression
- ☐ ☐ Systemic Lupus
- ☐ ☐ Epilepsy
- ☐ ☐ Dermatitis/Eczema/Rash
- ☐ ☐ HIV/Aids

Females Only

- ☐ Birth Control Pills
- ☐ Hormonal Replacement
- ☐ Pregnancy

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus _____

COMPLETE THIS SECTION ONLY IF THIS IS AN AUTO ACCIDENT OR WORK RELATED INJURY:

WORK RELATED: Date of injury:_____
Was accident reported to supervisor and/or employer
☐ YES ☐ No NAME_____
Date incident/accident reported:_____

Has a worker's compensation claim been filed?

☐ YES ☐ NO

Describe incident including causes and any surrounding circumstances_____
_____
_____
_____

Are you currently involved in any other w/c or auto injury claims? ☐ YES ☐ NO

TRAFFIC ACCIDENT: Date of accident:_____
What kind of vehicle was involved in accident?
☐ Truck ☐ Passenger Car ☐ Motorcycle ☐ Other_____

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Was your vehicle moving at time of accident? ☐ Yes ☐ No MPH____

Did your vehicle hit another object? ☐ Yes ☐ No Where?_____
Did other vehicles hit your vehicle? ☐ Yes ☐ No Where?_____
Was accident reported to Police? ☐ Yes ☐ No
Were any tickets issued? ☐ Yes ☐ No To whom?_____
Describe accident including causes and surrounding circumstances:_____
_____
_____

Are you currently involved in any other w/c or auto injury claims?
☐ YES ☐ NO

Patient Signature_____Date_____

Doctor Signature_____Date_____