Patient Basic Information

***NOTE: Please Fill This Out as Thoroughly 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**	**Dominant Hand:** ☐ **Right** ☐ **Left** ☐ **Both**	
Notification Preference: Please pick one! **Appointment Reminders / Recalls** ☐ **Text Msg.** ☐ **Call Cell** ☐ **Call Home** ☐ **Email**			
Occupation (describe briefly what you do)			
Employer Name and Address:			
Work Activities Include: ☐**Sitting** ☐**Standing** ☐ **Light Labor** ☐ **Heavy Labor** ☐ **Other**_____			
☐ **Part-Time** ☐ **Full-Time Student** **Where:**	**Marital Status:** ☐**Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**		
Spouse's/Significant Other's (SO) name:	**Date of Birth:**	**Spouse's/SO Occupation:**	
Spouse's/SO Employer / Address:	**Spouse's/SO Cell #:**	**Spouse's/SO Wk Phone:**	
Emergency Contact Information: (Name, Relationship to you, and Cell/Home phone)			
Days of Work Missed related to this Injury/Condition: _____ **days**	**Date returned to work?** _____ ☐ **Not yet back to work**	**Returned at:** ☐ **Light Duty** ☐ **Modified Duty** ☐ **Regular Duty**	

Have you ever suffered from any of the following Diseases, Disorders, Conditions, or Problems:

☐ Aids/HIV	☐ Allergies	☐ Anemia	☐ Anorexia	☐ Appendicitis	☐ Arthritis
☐ Alcoholism	☐ Asthma	☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts
☐ Bleeding	☐ Back Pain	☐ Chicken Pox	☐ Chem. Depend	☐ Epilepsy	☐ Herniated Disc
☐ Diabetes	☐ Breast Lump	☐ Dizziness	☐ Emphysema	☐ Hernia	☐ Mononucleosis
☐ Gonorrhea	☐ Digestive	☐ Heart Ds.	☐ Hepatitis	☐ Miscarriage	☐ Parkinson's Ds.
☐ Gout	☐ Glaucoma	☐ Measles	☐ Migraines	☐ Herpes	☐ Rheumatic Fever
☐ Kidney Ds.	☐ High Cholesterol	☐ Numbness	☐ Osteoporosis	☐ Multiple Sclerosis	☐ Stroke
☐ Mumps		☐ Pinched Nerve	☐ Psy. Care	☐ Pacemaker	☐ Thyroid
☐ Nervous	☐ Headaches	☐ Prosthesis	☐ Tuberculosis	☐ Rheu. Arthritis	☐ Typhoid Fever
☐ Polio	☐ Liver Ds.	☐ Scarlet Fever	☐ Ulcers	☐ Sinus Trouble	☐ Tumors/Growths
☐ Prostate	☐ Neuritis	☐ Tonsillitis	☐ Venereal Ds.	☐ Vaginal Infections	☐ Whooping Cough
	☐ Pneumonia				

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ **YES** ☐ **NO** ☐ **UNCERTAIN**

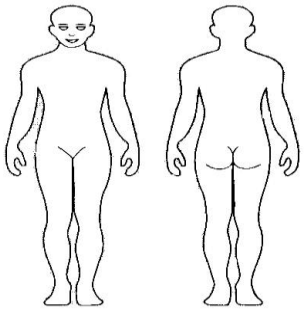
List All Surgeries:

Procedure_____**, Date / AGE**___ ;
Procedure_____**, Date / AGE**___ ;
Procedure_____**, Date / AGE**___ ;
Procedure_____**, Date / AGE**___ ;
Procedure_____**, Date / AGE**___ ;

Allergies: _____

List all Medications / Vitamins / Minerals:
(or what they are for)
(use back side if needed)

Draw in pain areas



Enter a Full Description of your Complaint, Condition, Accident, or Injury:
(when, where, how, & what hurts)

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.**_____

Treatment History: **Fill in any other doctor(s) seen prior to your 1st visit to this office.** ☐ **None**

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:** ____/____/____

Medications:_____

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:** ____/____/____

Medications:_____

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:** ____/____/____

Medications:_____

Follow-up instructions: _____