PATIENT NAME: **FIRST**_____ **MI**____ **LAST**_____

DATE OF BIRTH_____ **SSN**_____ **MALE**_____ **FEMALE**_____

STREET ADDRESS_____ **APT#**_____

CITY_____ **STATE**_____ **ZIP CODE**_____

MAILING ADDRESS IFDIFFERENT_____

HOME PHONE_____ **CELL PHONE**_____ **EMAIL**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

SPOUSE'S NAME_____ **CELL PHONE**_____ **WORK PHONE**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE**_____

REFERRING PHYSICIAN_____ **PHONE**_____

LAST DATE SEEN_____ **NEXT PHYSICIAN VISIT**_____

FAMILY PHYSICIAN_____ **PHONE**_____

ACCIDENT RELATED INJURY? YES___ **NO**___ **DATE OF ACCIDENT**_____

HOW DID YOU HEAR ABOUT US? □REFERRING PHYSICIAN □FAMILY □FRIEND □ATHLETIC TRAINER □OTHER_____

PRIMARY INSURANCE:_____ PHONE_____
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THEINSURED _____

SECONDARY INSURANCE:_____ PHONE_____
****A $10.00 FEE WILL APPLY TO FILE YOUR SECONDARY (DOES NOT APPLY TO MEDICARE)*
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THEINSURED_____

Patient Signature or Guardian if a minor **Date**

MEDICAL HISTORY

Please answer the following questions as applicable and sign the bottom of this form.

Heart Disease
□ Heart Attack
□Arteriosclerosis
□Rheumatic heart disease
□Heart murmur
□CHF
□Pacemaker/Defibrillator

Lungs
□Asthma
□Emphysema
□Turberculosis
□Shortness of Breath

Muscle Conditions
□Carpal Tunnel
□Tennis Elbow
□Back Problems
□Neck Problems

Blood Pressure
□Normal
□High
□Low

Other Conditions
□MultipleSclerosis
□Epilepsy/seizures
□Gout
□Lupus
□Sprains/Fractures
□Osteoporosis
□Cancer
□Hepatitis
□Diabetes
□Rheumatoid Arthritis
□Polio
□Night sweats/unexplained fevers
□Fainting
□Hearing loss
□Depression

□**Other conditions not listed above**: _____

- **Female Patients:** Are you pregnant? □Yes □No
- **Tobacco User:** □Yes □No
- **List known allergies:** _____
- **List any prior injuries:** _____ ❑**None**
- **List any current injuries:** _____ ❑**None**
- **List any prior surgeries**: _____

  _____ ❑**None**
- **List any current surgeries**: _____ ❑**None**
- **Please list any medications, including over the counter, you are currently taking (include pills, injections, and/or skin patches)** _____

  _____
- **Have you had physical therapy, speech therapy or chiropractic treatment in the current year? If yes, please explain:** _____
- **Are you currently receiving Home Health services (nursing, therapy, other)?** □Yes □No
- **Have you fallen or more times in the past year?** □Yes Date(s) of Fall(s)_____□No

_____

Patient Signature of Guardian if a minor **Date**