PERSONAL HISTORY

DATE: _______________ CHART NO. __________

Last Name: _________________________ First: ____________________ MI: _____ SSN: ______-_____-__________

Street Name: ____ E-mail: ______________________________

City: ___________________________________ State: ________________________ Zip: _______________________

Home Phone: (_____) _________________ Bus. Phone: (_____)________________ Cell: (_____) _______________

Emergency Contact Name: ____________________________ Emergency Contact Phone: (_____)_______________

Birthday: _____/_____/______________ Age: ________ Sex: _______ Height: _____________ Weight: __________

Driver License: _________________ State: ______ Circle One: Married Single Widowed Divorced Separated MINOR

Check One: ❑ FULL TIME ❑ PART-TIME ❑ RETIRED ❑ NOT EMPLOYED ❑ FULL TIME STUDENT ❑ PART TIME STUDENT

Employer/School Name: _______________________________________ Occupation: ________________________

Employer Phone: (_____) ________________ Employer Address: ____

Name of Spouse/Parent (if a minor): ________________________ Spouse/Parent Date of Birth: _____/_____/______

Spouse/Parent Employer:_ ______________________________________ Spouse/Parent SSN: ____-____-________

Spouse/Parent Employer Address: _____________________________ S/P Employer Phone: (_____) ____________

Is Today's Visit Related to: ❑ Automobile Accident ❑ Workers Compensation ❑ Other Physical Injury

Date of Injury: ______/______/______ Nature of Injury: ____

Have you been to see any other doctor for today's condition? ❑ Yes ❑ No

Doctor's Name: ____ Date of Visit: ______________________

What kind of treatment did you receive? ____

Referred to this office by: _______________________________________ Relationship: ____________________

FEMALE PATIENTS ONLY: Are you pregnant? ❑ Yes ❑ No Expected Date of Delivery: _____/_____/_______

Today's Date: _____/_____/________ Signature: ____

PAYMENT INFORMATION - Who is Responsible for your bill?

❑ Self

❑ Primary Medical Insurance: _____________________________________ ID No: __________________________

Policyholder: ____________________________________ Policyholder's Date of Birth: _____/_____/__________

❑ Secondary Medical Insurance: ___________________________________ ID No: _________________________

Policyholder: ____________________________________ Policyholder's Date of Birth: _____/_____/__________

❑ Automobile Accident - Contact: ________________________________ Claim No: _______________________

Insurance / Attorney Name: ___________________________________ Phone No: (_____) _______________

❑ Workers COMP - Contact: _____________________________________ Claim No: _______________________
Insurance Name: ____ Phone No: (_____) ________________

❑ Other (Please Explain): ____

PLEASE TURN TO BACK OF THIS PAGE...

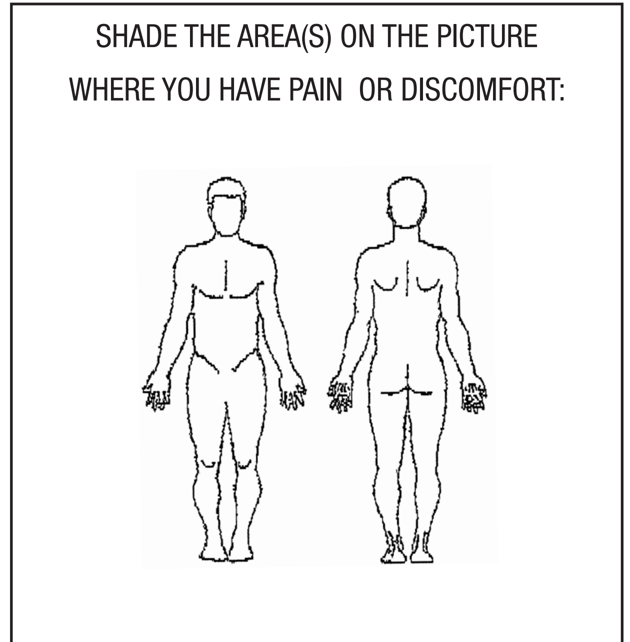
CONTINUED FROM FRONT OF THIS PAGE:...

What is your MAJOR COMPLAINT? ______________________________

How long have you suffered with this problem? ______________________________

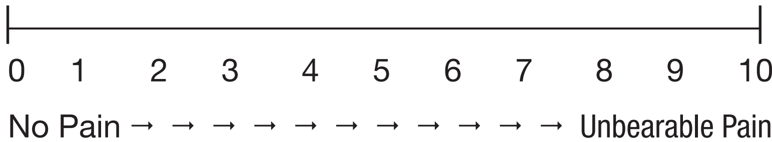
How often does this problem currently bother you? ______________________________

My Pain is:
- ❍ Sharp
- ❍ Dull
- ❍ Stabbing
- ❍ Throbbing
- ❍ Aching
- ❍ Shooting



Along with my MAJOR COMPLAINT, I also periodically have:
- ❍ Headache
- ❍ Mid-Back Pain
- ❍ Neck Pain
- ❍ Low Back Pain
- ❍ Pain, Numbness or Tingling in my Arms or Legs

Rate Your Pain Level for Today - Circle a Number:



0 1 2 3 4 5 6 7 8 9 10

No Pain → → → → → → → → → → → Unbearable Pain

Have you had:
- ❑ Spinal X-Rays? Date: ______________ Areas Taken: ______________
- ❑ MRI? Date: ______________ Areas Taken: ______________
- ❑ CT Scan? Date: ______________ Areas Taken: ______________

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

FAMILY	PAST	PRESENT	CONDITION	FAMILY	PAST	PRESENT	CONDITION
❍	❍	❍	Infection, Recent	❍	❍	❍	Dizziness / Fainting
❍	❍	❍	Bleeding Disorders	❍	❍	❍	Numbness in Groin / Buttocks
❍	❍	❍	HIV / AIDS	❍	❍	❍	Aneurysm
❍	❍	❍	Fever	❍	❍	❍	Cancer / Tumor
❍	❍	❍	Pacemaker	❍	❍	❍	Osteoporosis
❍	❍	❍	Heart Problems	❍	❍	❍	Diabetes
❍	❍	❍	Epilepsy / Seizures	❍	❍	❍	Trauma
❍	❍	❍	Blood Pressure Problems	❍	❍	❍	Visual Disturbances
❍	❍	❍	Inability to Control Bladder/Bowels	❍	❍	❍	Arthritis
❍	❍	❍	Prostate Problems	❍	❍	❍	Psychiatric/Psychologic Condition
❍	❍	❍	Corticosteroid Use	❍	❍	❍	Stroke (Date: __________)

Allergies: ______________________________

Surgeries: ______________________________

Medication(s): ______________________________

I certifiy that the information on this form is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

PATIENT SIGNATURE: ______________________________ DATE: ______________