



Today's Date: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (MI) (Nick Name)

Marital Status: \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_  
Street Number or P.O. Box City State Zip

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_  
Name and Relationship of person outside Immediate Home Phone Number

Name of Spouse: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Patients Employer: \_\_\_\_\_

School: \_\_\_\_\_ Sport: \_\_\_\_\_

Body Part: \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_  
Date of Injury/Accident Occurred: \_\_\_/\_\_\_/\_\_\_  
How did injury occur: \_\_\_\_\_  
Drug Allergies: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_/\_\_\_/\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_/\_\_\_/\_\_\_

Contract # \_\_\_\_\_ Grp# \_\_\_\_\_ Contract # \_\_\_\_\_ Grp# \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_ Policy Holders Employer: \_\_\_\_\_

Is this a WORKMAN COMPENSATION CASE? Yes \_\_\_ No \_\_\_ If yes, please provide the following:

Date Of Injury: \_\_\_/\_\_\_/\_\_\_ Employer: \_\_\_\_\_

Work Comp Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

List any Coach, Trainer, or Doctor and Complete Address that you want to receive a report.

Doctor: \_\_\_\_\_

Coach/Trainer: \_\_\_\_\_

Medical History      1. \_\_\_\_\_      4. \_\_\_\_\_  
    2. \_\_\_\_\_      5. \_\_\_\_\_  
    3. \_\_\_\_\_      6. \_\_\_\_\_

Current Medications: Please list ALL medications.

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|------------|------|-----------|------------|------|-----------|
| 1. _____   |      |           | 4. _____   |      |           |
| 2. _____   |      |           | 5. _____   |      |           |
| 3. _____   |      |           | 6. _____   |      |           |

Past Surgeries: Please list past surgeries in chronological order.

| Type of Surgery | Year | Type of Surgery | Year |
|-----------------|------|-----------------|------|
| 1. _____        |      | 3. _____        |      |
| 2. _____        |      | 4. _____        |      |

Family Medical History: Please list medical illness affecting your immediate family, e.g., parents and sibling.

| Disease  | Family Member | Disease  | Family Member |
|----------|---------------|----------|---------------|
| 1. _____ |               | 4. _____ |               |
| 2. _____ |               | 5. _____ |               |
| 3. _____ |               | 6. _____ |               |

Social History: Check appropriate line and fill in blanks.

Married \_\_\_      Single \_\_\_      Divorced \_\_\_      Widowed \_\_\_      Other \_\_\_      Alcohol \_\_\_

Alcohol:      Occasional \_\_\_      Daily \_\_\_      Heavy \_\_\_      No consumption \_\_\_

Tobacco:      Yes \_\_\_      No \_\_\_      Years Used \_\_\_      Packs Per Day \_\_\_      Drugs \_\_\_

General History: Please check if any apply.

GENERAL

\_\_Weight Change  
 \_\_Fever or Chills  
 \_\_Night Sweats  
 \_\_Urinary Frequency  
 \_\_Bleeding  
 \_\_Lumps or Masses  
 \_\_Dizziness or Fainting  
 \_\_Itching or Rash  
 \_\_Diabetes Mellitus  
 \_\_Thyroid Problems  
 \_\_Cancer

EAR-EYES-NOSE-THROAT

\_\_Visual Change  
 \_\_Hearing Change  
 \_\_Tinnitus  
 \_\_Dentures  
 \_\_Bleeding Gums  
 \_\_Hoarseness

GASTROINTESTINAL

\_\_Dysphasia (Difficulty in swallowing)

CARDIOVASCULAR

\_\_Heart DX/Pain  
 \_\_Hypertension  
 \_\_Mitral Valve Prolapse  
 \_\_Thrombophlebitis

RESPIRATORY

\_\_Cough/Sputum  
 \_\_Rheumatic Fever  
 \_\_Tuberculosis  
 \_\_Pleurisy Pneumonia  
 \_\_Asthma

GENITOURINARY

\_\_Urinary Infections  
 \_\_Incontinence  
 \_\_Venereal Disease  
 \_\_Menopause

MUSCULOSKELEAL

\_\_Backache  
 \_\_Joint Pain  
 \_\_Joint Swelling

BREAST

\_\_Lumps  
 \_\_Pain  
 \_\_Discharge

NEUROLOGIC

\_\_Seizures  
 \_\_Paralysis  
 \_\_Numbness  
 \_\_Weakness

\_\_Nausea & Vomiting      \_\_Jaundice      \_\_Hepatitis