Registration and History

Name:_____

Address: _____ City_____ State_____ Zip_____

Home #:_____ Work #:_____ Other #:_____

Date of Birth:_____ Social Security #:_____

Emergency Contact and phone #:_____
_____

Health Information

Main Complaint:_____

Other Complaint:_____

How long have you had this condition? _____ Have you had similar conditions in the past? YES / NO

Does this condition affect you at? Work/Family/Social, If any, how?:_____

What aggravates it? _____ What helps it? _____

Other Doctors seen for this condition?_____

Have you had any serious illness or currently under any other medical treatments besides mentioned above? YES / NO
If yes, please describe _____

Are you taking any medications? YES / NO If yes, please list:_____

Have you had any surgery, falls or accidents? YES / NO When? _____ Type? _____

Date of last physical exam _____ Physician's Name _____ Phone _____

Date of your last menstrual period? _____ Are you pregnant? YES / NO If yes, How long?_____ Due Date _____

Do you smoke? YES / NO Do you use alcohol? Yes / NO Do you use any other drugs? YES / NO

Family Medical History: _____

Have you had any allergic reactions to the following? (Please circle all that apply)

Aspirin	Iodine	Sedatives
Sleeping pills	Local Anesthetics (eg. Novocain)	Sulta Drugs
Foods	Penicillin or other Antibiotics	

Other, Please list _____

Have you ever had the following? (Please circle all that apply)

Anemia	Congenital Heart Lesions	Latex Sensitivity	Rheumatic Fever
Anorexia	Cough – Persistent/Blood	Liver Disease	Scarlet Fever
Arthritis	Diabetes	Measles	Short of Breath
Asthma	Emphysema	Migraine/Headaches	Sinus Trouble
Back Problems	Epilepsy	Mitral Valve	Skin Rash
Bleeding Tendency	Glaucoma	Prolapse	Stroke
Blood Disease	Heart Murmur	Mumps	Thyroid Problems
Blood Pressure High/Low	Heart Disease	Multiple Sclerosis	Tonsillitis
Cancer	Hepatitis-Type _____	Pacemaker	Tuberculosis (TB)
Chemical Dependency	Hernia	Pneumonia	Ulcer
Chemotherapy	Herpes	Polio	Venereal Disease
Chicken Pox	HIV/AIDS	Prostate Problem	Any Other _____
Chronic Fatigue Syndrome		Psychiatric Care	_____
Circulatory Problems	Kidney Disease	Resp. Disease	_____

Injury Information

Please complete for all injuries

Conscious? YES / NO Immediate Pain? YES / NO Police? YES / NO If yes, Police report # _____Ambulance? YES / NO

Hospital? YES / NO If yes, Where? _____ Testing? X-Ray / MRI / CT-Scan If yes, Where?_____

Work Injury

Date _____ Time _____ Location _____ Description _____

_____

_____

Insurance: _____ Address: _____

Case # :_____ Adjuster:_____ Phone :_____

Employer :_____ Phone :_____

Address: _____

Auto Accident

Date _____ Time _____ Location _____ Street _____ Description _____

_____

Were you? Driver / Passenger (where?) _____ / Pedestrian / Cyclist Seat Belt YES / NO Where you moving? YES / NO

Airbags Deployed? YES / NO Road Conditions? Wet / Dry / Other Did you hit your body? YES / NO Where? _____

Were you struck? By / Into another vehicle from? Behind / Right / Left / Front Type of vehicle? _____ # of occupants __

Insurance _____ Adjuster _____

Address _____ Phone _____

Claim # _____ Policy # _____

Insured's Name _____ Relationship to Patient _____ (If self, Please go to next section)

DOB _____ Social Security # _____ Telephone Number _____

Address (if different from patient) _____

Other Injuries

Please Explain: _____

Date _____ Time _____ Location _____ Description _____

_____