Patient Name: _____ Email: _____
(Last) (First) (M.I.)

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Cell ( ) _____-_____

Date of Birth: _____/_____/_____ Sex: M F Marital Status: M S D W

Employer Name and Address:_____

Referring Physician: _____ Phone No. ( ) _____-_____

Diagnosis: _____ Prescription date: _____/_____/_____

Primary Insurance
Carrier's Name: __ _____ Phone No. ( ) _____-_____

Policy/I.D. #: _____ Group #_____ Group Name: _____

Responsible Party Information

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Cell ( ) _____-_____

Date of Birth: _____/_____/_____

Health History

Are you taking any of the following medications?

☐ Nerve Pills ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers
☐ Muscle Relaxers ☐ Insulin ☐ Pain Killers (Including Aspirin)
☐ Other(s):

Check any of the following diseases or conditions you have ever been diagnosed with:

☐ Heat Attack / Stroke	☐ Heart Surg. / Pacemaker	☐ Heart Murmur
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Alcohol / Drug Abuse	☐ Veneral Disease	☐ Hepatitis
☐ HIV+ / Aids	☐ Shingles	☐ Cancer
☐ Frequent Neck Pain	☐ Emphysema / Glaucoma	☐ Anemia
☐ High / Low Blood Pressure	☐ Psychiatric Problems	☐ Rheumatic Fever
☐ Severe / Frequent Headaches	☐ Kidney Problems	☐ Ulcers / Colitis
☐ Fainting / Seizures / Epilepsy	☐ Sinus Problems	☐ Asthma
☐ Diabetes / Tuberculosis	☐ Difficulty Breathing	☐ Chemotherapy
☐ Lower Back Problems	☐ Artificial Bones / Joints	☐ Arthritis

☐ None of the Above

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

Please list previous surgeries/treatments with dates:

Please list any past serious accidents with dates:

Please list your family health history: