Practice:		Today's Date:			
Name:		_DOB:	Chart N	umber:	
Sex: ☐M ☐F Marital Status: ☐ Sing	gle 🗌 Married 🗌	Widowed 🗆 D	ivorced SS#:		
E-mail:		_ Spouse/Part	ner Name:		
E-mail newsletters, reminders, statements, etc.	Emergency N	Name:	Pho	one:	
Address:		_ City:	State:	Zip:	
Home #:	_ Cell #:		Other #:		
Employer:		Phone:			
Employer Address:					
Primary Insurance:			Are you the	insured? □Yes □No	
Insured Information			·		
Subscriber Name:		Relationshi	ip to insured: □Spouse	☐ Child ☐ Self ☐ other	
Phone #:			e □Female DOB:	<u> </u>	
Address:					
Policy ID:					
Secondary Insurance:			Are you the	insured? □Yes □No	
Insured Information					
Subscriber Name:		Relationshi	ip to insured: □Spouse	☐ Child ☐ Self ☐ Other	
Phone #:		Sex: □Mal	e □Female DOB:	_//	
Address:					
Policy ID:					
How did you find out about our prac	-		-	amily member Friend	
What is the reason for your visit too	lay?				
-		Re	sult of accident or w	ork injury? □Yes □No	
How long has this bothered you?	2 3 4 5 6	7 □ days □	weeks \square months \square	l years	
What treatments have you tried & I	nave they been	effective?			
On a scale of I-10 (I being no pain a	nd 10 being the	worst) what i	s your level of pain?	/10	
The pain quality is: □burning □con	stant □dull □s	harp □shooting	throbbing □tingli	ng Other:	
PLEASE READ AND SIGN The above information is correct to the best notifying the physician and/or medical staff of				nent, I am responsible for	

Date: _____

Patient Signature:

History and P	hysical N	ame:	DOB:	Chart N	umber:
☐ Liver ☐ Heart murmur ☐ Blood clot ☐ Neuropathy (specify) ☐ Arthritis (specify)	☐ Sleep apnea ☐ Stomach/bowe ☐ High choleste	☐ Gout el ☐ Depression erol ☐ Thyroid disease (☐ other (specify)	☐ Anxiety disorder ☐ High blood pressure (specify)	☐ Heart disease☐ Mental illness☐ Cancer☐ Diabetes (type I,	☐ Asthma☐ Kidney disease☐ Hepatitistype 2)☐ CVA
Surgical History		lectomy □ C-Section	☐Angioplasty ☐Bypass ☐	Cataracts □ Chole	ecvstectomy
			r anywhere else on your be		
					
Do you have any arr	tificial joints? 🗌 Y	es (where?) No Do you have	an artificial heart val	ve? □ Yes □ No
Do you drink alcoho Substance abuse: Yes, I had a past so No, I have never What is your occup	DI? Yes, every Yes, I have ubstance abuse prihad a substance aation?	day (5-7 days/week) [e a current substance oblem. Please specify buse problem	y? □ I □ 2 □ 3 □ 4 □ 5 Fo □Yes, occasionally/socially abuse problem. Please spec : □ □ □ Does it i arly □ Yes, I do the follow	□No/Rarely cify:	nding or □sitting
Family History Is Alzheimer's Arthritis Bleeding disorders Blood clot Cancer Cataracts Circulation proble Other (specify):	S		: (Please indicate family memb		
Pavian of System	on (Diaman alama), alama	· · · · · · · · · · · · · · · · · · ·	of these or make are on the order	"NIONIE"\	
Cardiovascular	☐ leg pain when w ☐ fainting		ny of these symptoms or check ☐ chest pain/pressure ☐ vascular disease	☐leg swelling ☐valve problems	□cold hands/feet □ NONE
Genitourinary	□blood in urine	hesitancy	□incontinence	□increased urgen	•
Gastrointestinal	☐decreased frequ ☐abdominal pain		nation □kidney disease □blood in stool □vomiting	□kidney stones □ulcers	□ NONE □ constipation
C astronicestina	□diarrhea	□trouble swall		_ : :: :	
Integumentary			□keloids □itchiness	□dry, scaly skin	□NONE
Hematologic		□sickle cell disease □		□clotting disorde	
Neurological	□tingling □tremors	□weakness □paralysis	□seizures	□numbness	□headaches □ NONE
Musculoskeletal		<u> </u>		muscle pain □arthritis	□neck pain □ NONE
Respiratory	□chest pain □shortness of bre	□wheezing eath □emphysema	□COPD	□coughing	□snoring □NONE
PLEASE READ AI					
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.					

Date:

Patient Signature:

Practice: **Today's Date:** Name: _Chart #: _____ Date of birth: _____ □Not Hispanic or Latino ☐ Declined to specify **Ethnicity:**

Hispanic or Latino Race: □Asian ☐ American Indian or Alaska Native ☐ Black or African American □White □ Native Hawaiian or other Pacific Islander ☐ Declined to specify Preferred Language: _____ ☐ Declined to specify _____ Pharmacy Phone: _____ **Pharmacy Name:** Pharmacy Address: City, State, Zip: Primary Care Physician: _____ Phone: _____ Date Last Seen: _____ Address: Referring Physician: Phone: Date Last Seen: Address: ___ **Privacy Information Preferences** Do you want to be exempt from public reporting? \Box Yes \Box No Can we send mail to the address on file? \Box Yes \Box No Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? \(\subseteq Yes \) If yes, please provide your e-mail address: Who can we leave messages with? □Wife □Husband □Daughter □Son □Other: Name(s): **Smoking Status** Vital Signs □ Current Every Day □ Smoker, Current Status Unknown Blood Pressure: _____ / _____ □ Current Some Day □ Heavy Tobacco □ Unknown If Ever Height: ______Weight: _____ □Former □Never □Light Tobacco □I decline to answer **Current Medications Allergies** ☐ No Known Allergies ☐ No Known Drug Allergies \square No Known Medications \square I take the following medications: Name / Dose: Name: _____ Reaction: ____ Name: _____ Reaction: _____ Name / Dose: Name: Reaction: Name / Dose: Name / Dose: ____ Name: _____ Reaction: _____ Name / Dose: Name: _____ Reaction: _____ Name / Dose: ____ Name: _____ Reaction: _____ Name / Dose: Name: Reaction: Name: _____ Reaction: _____ Name / Dose: Use the back of this form if more room is needed Last Flu Shot Date: _____ Did you get a pneumococcal vaccination? \(\subseteq Yes \subseteq No Have you fallen in the last 12 months? □Yes □No Were you injured from the fall? □Yes □No **Advanced Directives:** □ Living Will □ DNR □ Durable Power of Attorney □ Surrogate Appointed □ None PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible

for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature:

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D - 4			
Date:			
Ducc.			