Patient Information Sheet

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Age: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____

Current Complaint:

_____

_____

_____

_____

List of Medications:

1._____ 4._____

2._____ 5._____

3._____ 6._____

7._____ 9._____

8._____ 10._____

Medical Information

Chronic conditions:

- ☐ Diabetes
- ☐ Heart disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Gait Difficulties
- ☐ Numbness
- ☐ Chronic Pain
- ☐ Spinal Cord Injury
- ☐ Hyperlipidemia
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Other:_____

Allergies:_____

Family History of Medical Conditions:

- ☐ Stroke
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Aneurysm
- ☐ Migraines
- ☐ Progressive neurologic disease
- ☐ Dementia
- ☐ Others_____

Social Information:

- Smoking status: _____ Pack Years: _____
- Alcohol use: _____ Frequency: _____
- Recreational drug use: _____

Previous Surgeries + Dates: _____

_____