

PATIENT INFORMATION



PERSONAL INFORMATION

Full Name

Date of Birth

Gender

Male

Female

Address

Phone Number

E-Mail

Parents/Guardians

Status

Single

Married

Divorce

Others

Occupation

Please tell us the reason for your visit today:

EMERGENCY CONTACT DETAILS

Contact Name

Home Number

Relationship

Mobile Number

PRIMARY INSURANCE

Insurance Company

Claim Address on Back of Card

Subscriber/Member ID #

Group #

Subscriber Name & Middle Initial

Subscriber Date of Birth

SECONDARY INSURANCE

Insurance Company

Claim Address on Back of Card

Subscriber/Member ID #

Group #

Subscriber Name & Middle Initial

Subscriber Date of Birth

Date: _____

Signature: _____

Print name: _____

MEDICAL HISTORY



CURRENT HEALTH

Please check ALL conditions you currently have:

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis/tendonitis | <input type="checkbox"/> Neck/back injury | <input type="checkbox"/> Nursing / Pregnant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Abnormal skin condition | <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Recent injury | |
| <input type="checkbox"/> Allergies | _____ | | |
| <input type="checkbox"/> Other | _____ | | |

MEDICAL HISTORY

- | | | |
|--|------------------------------|-----------------------------|
| Do you have a history of heart/circulation problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of blot clots? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a high/low blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of high cholesterol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of STD/HIV? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any surgeries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, please explain:

SOCIAL HISTORY

- | | | | |
|-------------------------------|------------------------------|-----------------------------|-------------------------|
| Current or past NICOTINE use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If YES, how long? _____ |
| Current or past ALCOHOL use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If YES, how long? _____ |
| Current or past DRUG use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If YES, how long? _____ |

MEDICATION & SUPPLEMENTS

Please list any medications and/or supplements you are currently taking and the dosage:

PHARMACY

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