Total Health
Physical Medicine & Wellness

PATIENT INFORMATION **TODAY'S DATE:**___________

PATIENT NAME:______________________________ GENDER: MALE ___ FEMALE ___
DATE OF BIRTH:__________________________
ADDRESS:____
CITY:__________________________ STATE:____________ ZIP CODE:______________
PRIMARY PHONE NUMBER:__________________________ HOME___ CELL___ OTHER___
ALTERNATE PHONE NUMBER:________________________ HOME___ CELL___ OTHER___
EMAIL ADDRESS:____
EMERGENCY CONTACT:____
PHONE NUMBER:________________________________ RELATIONSHIP:________________________
OCCUPATION:___________________________________ EMPLOYER:__________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:____
POLICY HOLDER NAME:______________________________
POLICY HOLDER DATE OF BIRTH:____________________
POLICY ID OR SS#:__________________________________
(PLEASE NOTE THAT THE MAJORITY OF OUR TREATMENTS ARE NOT COVERED BY INSURANCE)

REFERRAL SOURCE

HOW DID YOU HEAR ABOUT OUR CLINIC? ____
WHO MAY WE THANK FOR REFERRING YOU? ____

RELEASE OF INFORMATION

MARITAL STATUS: ____ MARRIED ____SINGLE ____ DIVORCED ____ SEPARATED
____ WIDOWED
IF MARRIED, SPOUSE'S NAME:____

WHO MAY WE RELEASE INFORMATION TO?
NAME:____ PHONE NUMBER:____________________
NAME:____ PHONE NUMBER:____________________

PRIMARY CARE PROVIDER NAME:____
LOCATION: ____________________________ PHONE NUMBER:_____________________________
** WE ARE A SPECIALTY CLINIC, SO WE HIGHLY RECOMMEND THAT YOU HAVE A PCP FOR BASIC NEEDS

PATIENT SIGNATURE:____

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HEALTH HISTORY

WHAT BRINGS YOU IN TODAY?

____

____

IS THIS CONDITON RELATED TO AN INJURY?____________________

IF YES, PROVIDE DETAILS:______________________________

____

ARE YOU UNDER THE CARE OF AN ATTORNEY FOR THIS INJURY?________________

ATTORNEY NAME:______________________ PHONE NUMBER:______________________

CURRENT SYMPTOMS/PROBLEMS:

___ NECK PAIN/STIFFNESS	___ NERVE PAIN	___ ANXIETY	___ SUDDEN WT LOSS
___ BACK PAIN/STIFFNESS	___ MUSCLE SPASMS	___ DEPRESSION	___ ABNORMAL WT GAIN
___ARM/HAND PAIN	___ FATIGUE	___ POOR CONCENTRATION	___ VAGINAL DRYNESS
___ LEG/KNEE PAIN	___ SLEEPING DIFFICULTIES	___ MOOD SWINGS	___ LOW SEX DRIVE
___ HEADACHES	___ ALLERGY/SINUS ISSUES	___ NIGHT SWEATS	___ ERECTILE PROBLEMS
___ DIZZINESS/VERTIGO	___ FREQUENT ILLNESS	___ HOT FLASHES	___ SEVERE DRY SKIN
___ BREATHING ISSUES	___ VISION CHANGES	___ FREQUENT URINATION	___ PALPATATIONS
___ STOMACH PROBLEMS	___ HOT/COLD INTOLERANCE	___ FREQUENT UTI'S	___ CHEST PAIN
___ POOR ENDURANCE	___ IRRITABILITY	___ SUICIDAL THOUGHTS	

OTHER SYMPTOMS:____

____

____

MEDICAL HISTORY (PER DIAGNOSIS OR TREATMENT)

HORMONE PROBLEMS____________________	MENOPAUSE/HYSTERECTOMY____________________
DEPRESSION/ANXIETY____________________	ADD/ADHD ____________________
PROSTATE PROBLEMS____________________	KIDNEY PROBLEMS____________________
CARDIAC PROBLEMS____________________	RESPIRATORY ISSUES____________________
STOMACH PROBLEMS____________________	BOWEL ISSUES____________________
THYROID PROBLEMS____________________	NEUROLOGIC ISSUES ____________________
AUTO IMMUNE PROBLEMS________________	ANEMIA/BLEEDING DISORDERS________________

OTHER:____

SURGICAL HISTORY:____

____

MEDICATION ALLERGIES:____

OTHER ALLERGIES:____

PREFERRED PHARMACY:______________________________________

CURRENT MEDICATIONS. PLEASE INCLUDE NAME, DOSE, FREQUENCY, AND WHO PRESCRIBES IT:

____

____

____

____

____

CURRENT SUPPLEMENTS/VITAMINS:____

____

WOMEN ONLY: LMP:________________ ANY POSSIBLITY OF PREGNANCY? ____ YES ____ NO

SOCIAL HISTORY: DO YOU SMOKE? ___ YES ___ NO
OTHER TOBACCO PRODUCTS? ___ YES ___ NO
FREQUENCY OF ALCOHOL? ______ DRINKS PER WEEK
CAFFINE INTAKE? ___________

IS THERE A FAMILY HISTORY OF ANY MEDICAL PROBLEMS?
CONDITION:________________________________ FAMILY MEMBER(S)________________________
CONDITION:________________________________ FAMILY MEMBER(S)________________________
CONDITION:________________________________ FAMILY MEMBER(S)________________________

____
PATIENT SIGNATURE DATE