New / Annual Patient History

(Please be as detailed as possible)

Patient First Name: _____ Patient SSN: _____

Patient Last Name: _____ Date Of Birth: _____

☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Race _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religion _____

Address: _____

City State Zip

Home Phone # _____ Cell Phone # _____

Employer: _____ Phone: _____

Email Address _____ Pharmacy & Location _____

Primary Care Physician

Physician Name: _____ Phone: _____

Address: _____

Primary Insurance

Type: _____ Effective Date: _____

Policy Holder's Name: _____ Relationship to PT: _____

Policy Holder's Address: _____ Phone: _____

Policy #: _____ Group #: _____

Billing Address: _____

Date of Birth: _____ SSN: _____ Employer: _____

Do you have a CoPay? Yes or No, If yes how much? $ _____

Does your insurance require a referral to see a Specialist? Yes or No

It is your responsibility to inquire and bring your referral to each appointment

Secondary Insurance

Type: _____ Effective Date: _____

Policy Holder's Name: _____ Relationship to PT: _____

Policy Holder's Address: _____ Phone: _____

Policy #: _____ Group #: _____

Billing Address: _____

Date of Birth: _____ SSN: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you learn of our Practice: _____

HIPPA INFO: Instructions for the office when returning phone calls or reminding you about appointments. I authorized the office to contact me at: ☐ Home ☐ Work ☐ Cell and may leave messages at: ☐ Home ☐ Work ☐ Cell

I authorize the office to leave detailed messages about appointments / phone calls: ☐ Yes ☐ No

If you prefer us to leave messages with a specific individual, please list: _____

Name:_____ SSN: _____

Authorization and Consent: I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I also authorize insurance payment be made directly to the physician. I give consent for evaluation and treatments, including testing and medical treatments for me or my dependent. I understand shall there be a problem or denial from my insurance company that I remain responsible for all services rendered.

Signature: _____Date: _____

***Please be as specific, truthful and accurate as possible**.

Reason for visit: _____

_____

Other Problems: 1._____2. _____

3. _____4._____

5._____6._____

Current Medical Problems /Symptoms (Do not enter previous problems here)

☐ Abdominal Pain – Chronic	☐ Back Pain:– ☐ Upper	☐ Lower
☐ Appetite – Loss	☐ Chills	☐ Fever
☐ Cough	☐ Congestion	☐ Chest Pain
☐ Constipation	☐ Difficulty Sleeping	☐ Elevated blood pressure
☐ Decreased urination	☐ Diarrhea	☐ Fast Heart beat
☐ Facial pain	☐ Frequent urination	☐ Headaches
☐ Joint pain	☐ Muscle Weakness	☐ Nausea
☐ Vomiting	☐ Neck pain	☐ Palpitations
☐ Sinus Trouble	☐ Sneezing/Sniffing	☐ Slurred Speech
☐ Swallowing Difficulty	☐ Shortness of breath?	
☐ Snoring- Do you stop Breathing?	☐ Yes ☐ No	☐ Throat – Sore – Frequent
☐ Weak arms or legs	☐ Weight gain	☐ Weight Loss

☐ Other_____

_____

_____

_____

Name:_____ SSN: _____

Previous Medical Problems: (please elaborate on the side)

- ☐ Aneurysm , if yes location _____
- ☐ Angina
- ☐ Coronary artery disease
- ☐ Atrial fibrillation
- ☐ Atrioventricular block (heart block)
- ☐ Hypertension
- ☐ Cardiac arrest
- ☐ Congestive Heart Failure
- ☐ Cardiomyopathy
- ☐ Elevated blood pressure
- ☐ Arrhythmia
- ☐ Stroke
- ☐ Allergic Rhinitis
- ☐ Bronchitis
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Hemoptysis (coughing blood)
- ☐ Lung infection /abscess
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Respiratory failure
- ☐ Sinusitis
- ☐ Pneumothorax
- ☐ Ulcer where _____
- ☐ Hemorrhoids/ Anal fissure
- ☐ Colon cancer
- ☐ Celiac disease
- ☐ Cirrhosis of liver
- ☐ Ulcerative Colitis
- ☐ Crohns disease
- ☐ Constipation
- ☐ Diarrhea – Functional
- ☐ Gastrointestinal Bleeding
- ☐ Esophageal reflux
- ☐ Hepatitis
- ☐ Diabetics--- Type 1 ☐ Type 2 ☐
- ☐ Hyperlipidemia(High cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Autoimmune disease
- ☐ Obesity
- ☐ Postural hypotension
- ☐ Vitamin Deficiency
- ☐ Alzheimer's
- ☐ CVA (Stroke)
- ☐ Migraine
- ☐ Meningitis
- ☐ Myoclonus
- ☐ Parkinson's
- ☐ Kidney stone
- ☐ Chronic Kidney Disease
- ☐ Anemia
- ☐ ESRD(End stage renal disease
- ☐ Blood Disorder
- ☐ Bleeding _____
- ☐ Sickle Cell Anemia
- ☐ Anemia
- ☐ Sickle cell trait
- ☐ Arthritis
- ☐ Back pain--- ☐ neck ☐ upper ☐ lower
- ☐ Fractures
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Rotator cuff tear
- ☐ Breast mass
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Skin Abscess
- ☐ Cellulitis
- ☐ Decubitus Ulcer Rash
- ☐ Bipolar disorder
- ☐ Anxiety/Panic attack
- ☐ Depression
- ☐ Obsessive/Compulsive disorder
- ☐ Schizophrenia
- ☐ Abnormal pap smear
- ☐ Vaginitis
- ☐ Endometriosis
- ☐ STD -Which one? _____
- ☐ Traumatic brain injury
- ☐ Positive TB/ PPD skin test
- ☐ Tuberculosis
- ☐ Hernia

Previous medical problems _____

_____

_____

_____

Name:_____ SSN: _____

Past Medical History: **(FEMALES PLEASE COMPLETE)**

Pregnant? Yes☐ No☐ Planning Pregnancy? Yes☐ No☐
Menstrual Flow: ☐Irregular ☐Regular ☐Pain / Cramps ___ Days of Flow ___ Length of Flow
Date: First day of last Period: _____ Pain / Bleeding after Sex: ☐
Number of: ____Pregnancies ____Abortions ____Miscarriages ____Live Births
Birth Control Method: _____
B.C. Pill Name: _____
Flushing / Menopause
Date of last PAP Test: _____ ☐Normal ☐ Abnormal
Date of last Mammogram: _____ ☐Normal ☐ Abnormal

Previous or Recent Surgeries: (Complete list with dates)

☐ Tonsils and Adenoids Surgery ☐ Hysterectomy - ☐ Partial ☐ Total
☐ Gallbladder Surgery ☐ Appendix Removal ☐ C-Section
☐ Hernia Repair ☐ Splenectomy
☐ Heart Surgery : If yes , ☐ Bypass ☐ Valvular ☐ Pacemaker ☐ Defibrillation ☐ Other
Other_____ Other_____
Other_____ Other_____
Other_____ Other_____
Other_____ Other_____

Medication List: (List all medications including over the counter, eye drops & herbal remedies)

Name	**Dose (mg, mcg)**	**how often do you take it?**

Name:_____ SSN: _____

Immunizations:

Have you had this vaccine before?	**Yes**	**No**	**If yes, when was the last and how many doses in the past ?**
Haemophilus B			
Hepatitis A			
Hepatitis B			
Human Papilloma Virus (HPV)			
Influenza			
Measles / Mumps / Rubella (MMR)			
Meningococcal			
Pneumonia			
Tetanus			
Varicella (Chicken Pox)			
Zoster (Shingles)			

Allergy List: (Check all that apply and Please Indicate Nature of Allergic Reaction. Ex. Hives, rash.)

- ☐ Penicillin
- ☐ Latex Exam Gloves
- ☐ Nsaids
- ☐ Digitalis Glycosides
- ☐ Meperidine & Related
- ☐ Erythromycin
- ☐ Phenytoin
- ☐ Quinolones
- ☐ Adhesive Tape
- ☐ Ultram
- ☐ Iodine
- ☐ Carbamazepine
- ☐ Codeine Phosphate
- ☐ Ethiodized Oil
- ☐ Morphine Sulfate
- ☐ Opioid Analgesics
- ☐ Sulpha
- ☐ Lidocaine
- ☐ Tetracycline
- ☐ Sulfonylureas
- ☐ Shellfish
- ☐ Cephalosporin
- ☐ Codeine Sulfate
- ☐ Glucocorticoids
- ☐ Sulfur
- ☐ Phenothiazine
- ☐ Insulin
- ☐ Salicylates
- ☐ Tuberculin Tests

_____

_____

_____

Other Allergies (Food or Environmental):

_____

_____

_____

Name:_____ SSN: _____

Family History of Medical Problems: (Check all that apply)

	Father	Mother	Children	Brother	Sister	Paternal Mother	Paternal Father	Maternal Mother	Maternal Father
Alcoholism									
Asthma									
Cancer									
Diabetes									
Epilepsy									
Glaucoma									
Hair Loss									
Heart Disease									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Migraine									
Osteoporosis									
Stroke									
Thyroid Disease									
Bleeding Disorder									
Other									

Social History :

Alcohol ☐ Yes ☐ No
Type: _____
Amount:_____

☐ Sleep: Difficulty Falling Asleep
☐ Continuity Disturbances ☐ Daytime Drowsiness
☐ Early Morning Awakening ☐ Other _____

☐ Coffee:
Cups Daily: _____

☐ Other Caffeine
Type:_____

☐ Salt Intake – Add salt to table food?

☐ Exercise Regularly

☐ Drugs:
☐ Heroine ☐ Barbiturates
☐ Marijuana ☐ Narcotics
☐ Inhalants ☐ Tobacco Stimulants
☐ Cocaine ☐ Depressants

Smoke: ☐ Yes ☐ No Packs Daily: _____
How Long? _____
Interested in stopping? _____

Interested in stopping? _____

Level of Education Completed:

☐ Elementary ☐ Middle ☐ High school ☐ College 2 yrs ☐ College 4yrs ☐ Post graduate

Domestic Violence: ☐ Yes ☐ No

Partner ☐ Yes ☐ No If yes, ☐ Man ☐ Woman