Client Information (*Please complete all areas*)

NAME First: ________________________Middle: ________________________Last____________________
Referral Date: __________________ Gender: ____________
Birthdate:_________________ Language: ___________
Age: _______ Ethnicity: ____________
Social Security Number: ______-_____-________ Race: ____________
Preferred Name: _______________________________ Marital Status:____________
Pregnant (check one): Yes___ No ___ Male NA____
Any Allergies: ____
____

Primary Address ____
City______________ State____________ Zip _____________ County ____________
Secondary Address ____
City______________ State____________ Zip _____________ County ____________

Phone/Communications
Home: __________________________
Work: __________________________
Cell: ___________________________

Emergency Contact
Name: ___________________________
Relationship: _____________________
Phone number: ___________________

Medical History

Family Doctor/ Pediatrician Name: ____
Location: ____
Children Immunizations current? Yes___ No ____ Did you bring Documentation? ____________

Exam History
Physical Date: _______________ Doctor: _________________________
Dental Date: _______________ Doctor: __________________________
Hearing Date: _______________ Doctor: _________________________
Eye/Vision Date: _______________ Doctor: _______________________

Recent Lab Results
Test 1 Date: _________________ Lab Type: _____________________________ Results: ______________________
Test 1 Date: _________________ Lab Type: _____________________________ Results: ______________________

DRUG PROFILE - CURRENT MEDICATIONS:

SIGNATURE & DATE	MEDICATION	DOSE/SIG	DOCTOR	DATE ON	DATE OFF

Comments:
____
____

MEDICAL PROBLEMS/HISTORY: (Check appropriate box and complete necessary information)

Yes No Are you/client being treated for any ongoing medical problems at this time? If yes, specify below
____

Name of treating doctor, if other than family doctor: ____

Yes No Are you/client having any medical problems and not receiving treatment? If yes, specify below
____

Yes No Have you/client had any significant medical problems in the past? If yes, specify below
____

Yes No Is there a history of any serious illnesses or chronic medical problems in your family? If yes, specify below

____

Yes No Have you/client had any accidents/injuries requiring medical attention? If yes, specify below

____

No Yes Have you/client had any operations? If yes, specify below (reason, when. where)

____

Are you/client currently experiencing physical pain, or have you/client experienced pain in the recent past?

If yes, describe intensity/character of pain (Circle appropriate #): 1 (Very little) 2 3 4 5 (Severe pain)

Known/Suspected Cause:____

Frequency of the pain:____________ Duration of the Pain:_______________ Location of the pain:_________________

When did you experience pain last:_____________

What helps the pain (include medications, treatments; by whom, include self-treatments, etc.) :

____

For women, have you had past pregnancies/deliveries? If yes, specify number______________________

Any complications in pregnancy and/or delivery: ____

HEALTH RELATED BEHAVIORS:

Yes No Do you/client receive routine dental care?

Date of last exam: ____________ With: _________________________________

Yes No Do you/client have vision problems requiring glasses?

Date of last exam: ____________ With: _________________________________

Yes No Do you/client have hearing problems requiring a hearing aid?

Date of last exam: ____________ With: _________________________________

Yes No Do you/client smoke cigarettes /use tobacco? If yes, how many per day? _____________________

Yes No Do you/client drink alcohol or use drugs recreationally or to reduce stress?

If yes, what, how much, how often? ____

Yes No Do you/client exercise regularly?

Yes No Do you/client have problems with mobility that interferes with day-to-day activities?

Yes No Do you/client have concerns about your current weight? _________ Height _________ Weight

Yes No Are you a registered sex offender?

Additional Information/ Comments:

____

____

____

____

How did you hear about us?

____

Releases of Information

Contact: Last Name ________________________ Frist Name: ___________________________

Organization: ____

Address: ____

City: _________________________ State: _______ Zip: _________ Fax: ___________________

Any limitations: ____

Contact: Last Name ________________________ Frist Name: ___________________________

Organization: ____

Address: ____

City: _________________________ State: _______ Zip: _________ Fax: ___________________

Any limitations: ____

Contact: Last Name ________________________ Frist Name: ___________________________

Organization: ____

Address: ____

City: _________________________ State: _______ Zip: _________ Fax: ___________________

Any limitations: ____

Contact: Last Name ________________________ Frist Name: ___________________________

Organization: ____

Address: ____

City: _________________________ State: _______ Zip: _________ Fax: ___________________

Any limitations: ____

Contact: Last Name ________________________ Frist Name: ___________________________

Organization: ____

Address: ____

City: _________________________ State: _______ Zip: _________ Fax: ___________________

Any limitations: ____