PATIENT INFORMATION FORM

Patient Name:_____ **Date of Birth:____/____/_____**

Reason For Today's Visit:	**Date of onset: ____/____/_____**	**Side of body (if applicable):** Left Right

IS THIS A WORKERS COMP CLAIM? Yes No	**IF YES, WHAT IS THE BILLING ADDRESS?**

Drug Allergies:	**Current Medications:**

Past Medical History:	**Past Surgical History:**	**Do You:**
o Heart Disease o High Blood Pressure o High Cholesterol o Kidney Disease o Liver Disease o Anemia o Hypothyroidism o Hyperthyroidism o Diabetes o Headaches o Depression o Anxiety o Asthma o COPD o **Other:**	o Appendectomy o Gall Bladder o Hernia o Hysterectomy o Abdominal Surgery o Knee Surgery o Hip Surgery o Tonsillectomy o Wisdom Teeth o Cesarean Section o Ear Tubes o **Other:**	**Smoke or Chew Tobacco?** **Yes No** If Yes, ____ packs per week **Drink Alcohol?** **Yes No** If Yes, ____drinks per: week or month (circle) **Use Recreational Drugs?** **Yes No** If Yes, Which ones and how often?

Is there anything else we should know in order to make sure we address your needs?

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