Patient Introduction Form

Name: _____ Date: _____

Address: _____City: _____ST._____ ZIP _____

Sex: M / F D.O.B. ____/_____/_____ Age: _____ Height: _____ Weight: _____

Home Phone: ( ) _____- _____ Cell: ( ) _____-_____ Work: ( ) _____-_____

E-mail Address: _____@_____. com Referred by _____

SS# _____-_____-_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer Name/Address: _____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____- _____ Cell: ( ) _____-_____ Work: ( )_____-_____

Attorney Name: _____ Attorney Phone # ( ) _____-_____

Current Symptom #1: _____
Current Symptom #2: _____

Insurance Information

Insurance Co. _____ ID/Policy #: _____
Insurance Phone #: ( ) _____-_____
Policy Holder's Name: _____ D.O.B.: _____
Secondary Ins. Co. _____ ID/Policy#: _____
Phone #: ( )_____ - _____

EXERCISE:
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY:
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS:
□ Smoking – Packs per day _____
□ Alcohol - Drinks per week _____
□ Coffee/Caffeine Drinks- Cups per day_____
□ High Stress Level - Reason_____

Medications and Conditions:	**Surgeries (Area):**	**Date:**

Please check off all Medical Conditions that Apply:

AIDS/HIV		HEART DISEASE		PROSTATE PROBLEMS	
ALCOHOLISM		HEPATITIS		PSYCHIATRIC CARE	
ARTHRITIS		HERNIA		RHEUMATOID ARTHRITIS	
ASTHMA		HERNIATED DISC		STROKE	
CANCER		HIGH CHOLESTEROL		THYROID PROBLEMS	
FRACTURES		MIGRANE HEADACHES		VAGINAL INFECTIONS	
GOUT		OSTEOPOROSIS		OTHER:	
DIABETES		PINCHED NERVE		OTHER:	

I would like to use text message to make, confirm, reschedule, or cancel my appointments? □ Yes □No

I understand that standard text rates as determined by my cellular provider may apply.

Patient Signature: _____