|  |
| --- |
| PERSONAL INFORMATION |
| Name: | E-Mail: | Race (optional): |
| Date of birth: | Male or Female | SSN: | Phone: |
| Alternate Phone: | Local Pharmacy: | Mail Order Pharmacy: |
| Mailing Address: | City: | State: | ZIP Code: |
| Physical Address | City: | State: | Zip Code |
| Insurance Name: | ID#:  | Policy Holder: |
| Previous Physician: | Current Established Family: |
| Emergency Contact: | Relationship: | Contact Phone: |
| Complete list of current prescription and over the counter medications See back [ ]  See attatched [ ]  |
| 1. | Dose: | 2. | Dose: |
| 3. | Dose: | 4. | Dose: |
| **HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS FOR PAIN IN THE LAST 12 MONTHS?** (Circle yes or no) | **YES** | **NO** |
| If YES, list Why, Medication, and Dose: |
| Current and past Medical history (Please list) See back [ ]  See attatched [ ]  |
|  |  |  |  |
|  |  |  |  |
| **Do you suffer from any type of Chronic Pain?** | **YES** | **NO** | If YES, please explain. |
| **Do you have history of Substance or Alcohol Abuse?** | **YES** | **NO** | If YES, please explain. |
| **Preventative Health Exams:** Date of last: | Thorough health exam: | Pap Smear: | Mammogram: | Colonoscopy: |
| allergies/intolerance and reactions to all medications and other known allergies See back [ ]  See attatched [ ]  |
| 1. | Reaction: | 2. | Reaction: | 3. | Reaction: |
| Surgical History and date See back [ ]  See attatched [ ]  |
| 1. | Date: | 2. | Date: |
| 3. | Date: | 4. | Date: |
| Hospitalizations and date (including Pregnancies) See back [ ]  See attatched [ ]  |
| 1. | Date: | 2. | Date: |
| 3. | Date: | 4. | Date: |
| Family history (please indicate relationship – i.e. father or mother – OR “n/a”) See back [ ]  See attatched [ ]  |
| Diabetes: | High Blood Pressure: | Heart Disease: |
| Alcoholism: | Stroke: | Mental Illness: |
| Cancer: | Other: |
| Social History (please answer accordingly or write yes or no) See back [ ]  See attatched [ ]  |
| Employer Name: | Employment Status: Full-Time **[ ]** Part-Time **[ ]**  Self Employed **[ ]** Retired **[ ]**  Not Employed **[ ]**  |
| Student Status: Full-Time **[ ]** Part-Time **[ ]** Not a Student **[ ]**  | Marital Status: | Sexually Active: | Religion: |
| Do you Smoke? | Have you ever? | Packs per day? | How many years? | Year quit? |
| Do you Chew? | Have you ever? | Cans per day? | Cans per week? | Year quit? |
| Alcohol Use? | Have you ever? | How often? | Drug Use? | Do you use Marijuana? | Card? |
| **Date of last vaccine:** | Flu: | Tetanus: | Pnuemovax: | Hep B or A: | Shingles: |
| Signature |
| Patient Signature: | Date: |

#