



New Patient Registration Form

Identification

Last Name	First Name	Middle Initial	Birth Date
Street	City	State	Zip
<input type="checkbox"/> M <input type="checkbox"/> F	Home Phone	Work Phone	Occupation

Physician Information

Primary Physician	Referring Physician
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Medical History

Known Allergies
Latex Sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No
Check each box to indicate whose care you are under <input type="checkbox"/> Medical Doctor(MD) <input type="checkbox"/> Psychiatrist/Psychologist <input type="checkbox"/> Osteopath <input type="checkbox"/> Physical Therapist(PT) <input type="checkbox"/> Dentist <input type="checkbox"/> Chiropractor Other _____
Have you EVER been diagnosed with any of the following conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer If so, specify _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency (i.e. alcoholism) <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis

- Yes No Other arthritic conditions
- Yes No Depression
- Yes No Hepatitis
- Yes No Tuberculosis
- Yes No Stroke
- Yes No Kidney Disease
- Yes No Anemia
- Yes No Epilepsy
- Yes No Other
- Yes No During the past month have you felt down, depressed, or hopeless?
- Yes No During the past month have been bothered by having little interest or pleasure in doing things?
- Yes No FOR WOMEN: Are you currently pregnant or believe to be pregnant?

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Date	Reason for Surgery/Hospitalization

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- Yes No Diabetes
- Yes No Tuberculosis
- Yes No Heart Disease
- Yes No High Blood Pressure
- Yes No Stroke
- Yes No Kidney Disease
- Yes No Alcoholism (chemical dependency)
- Yes No Cancer
- Yes No Arthritis
- Yes No Anemia
- Yes No Headaches
- Yes No Epilepsy
- Yes No Mental Illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- Yes No Aspirin
- Yes No Tylenol
- Yes No Advil/Motrin/Ibuprofen
- Yes No Laxatives
- Yes No Decongestants
- Yes No Antihistamines
- Yes No Antacid
- Yes No Vitamins/Mineral Supplements
- Yes No Other _____

Please list any PRESCRIPTION medication you are currently taking (including pills, injections, or skin patches):

Prescription

How much caffeinated coffee or caffeine containing beverages do you drink per day?

How many packs of cigarettes do you smoke a day? _____

Have you recently noted:

- Yes No Weight Loss/Gain
- Yes No Nausea/Vomiting
- Yes No Fatigue
- Yes No Weakness
- Yes No Fever/Chills/Sweats
- Yes No Numbness/Tingling