Welcome

Patient Information

First Name:	Last Name:	Date:…./……/…….
Date of Birth:	Place of birtht:	Height:
Weight:	Shoe size:	Leg length (For admin):
Sex:	Marital Status:	Number of Children:
Occupation:	For How Long:	
Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
SS #	ID #	
E-mail Address:		

Emergency Contact

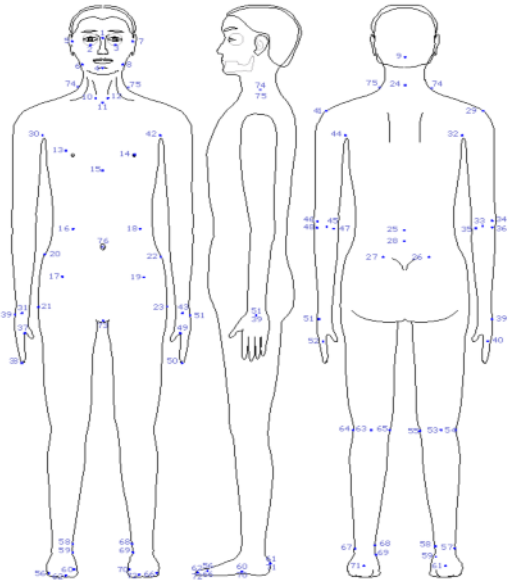
Name and Address:		
Home Phone:	Cell Phone:	Relationship:
Whom should we thank for referring you to us?		

Diagrams

- Place a **circle** where you feel pain.

- Draw an **arrow** from the circle if the pain travels to other parts of the body.

- Place **X's** at any areas of numbness or tingling.



Pain Evaluation

Rate the severity of your pain. (1 to 10: mild to severe)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Symptoms

Primary Complaint:	Date of Onset:	Circumstances of Onset:
Type of Pain: **(Please Circle at Right)**	Sharp Dull Throbbing Numbness Aching Shooting	Burning Tingling Cramps Stiffness Swelling Other
How often does it bother you?	Constant:ly Specific Tme of Day Specific Tme of Night	Weekly Monthly Seasonally
Which activities are difficult to perform?	Sitting Walking Standing Bending	Lying Down Changing Position Other
What eases the pain?	Hot Packs Cold Packs	Medication (Specify) Other
Have you experienced the same pain previously?	Yes No	If Yes, When?
Did you require emergency room care?	Yes No	If Yes, When?
List health care providers seen for this condition:	Names: Date: - - - - - -	Diagnosis: - - -
List any medications that you are currently taking:		
Did your complaint require hospitalisation?	Yes No	If Yes, When?

Daily Habits and Diet

Your Present Lifestyle Habits	Coffee: Cups per Day: Tea: Cups per Day:	Smoking: Packs per Day: Alcohol: No. Drinks per Day:
Daily exercise - level and type (Circle):	None Moderate Heavy	Walking Biking Gym Weightlifting Running Yoga Tennis Other
List any vitamins/supplements you take:		

Have you gained or lost any weight in the past 6-12 months?	Yes No	If Yes, How Much?
Do you have any food allergies?	Yes No	If Yes, Please List:
Do you have any dietary restrictions?	Yes No	If Yes, Please List:
Do you drink sufficient liquids?	Yes No	Specify: Water - Glasses per Day: Sodas - Glasses per Day: Other - Glasses per Day:

Health History (Please Circle)

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attempt
Alcoholism	Chemical Dependency	Hernia	Pacemaker	Thyroid Problem
Allergies	Chicken Pox	Herniated Disc	Parkinson's Disease	Tonsilitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Ulcers
Appendicitis	Emphysema	Kidney Disease	Polio	Tumor / Growths
Arthritis	Epilepsy	Liver Disease	Prostate Problem	Typhoid Fever
Asthma	Fractures	Measles	Prosthesis	Vaginal Infection
Bleeding Disorders	Glaucoma	Migraine / Headaches	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Miscarriages	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Mononucleosis	Rheumatoid Fever	Other:
Bulimia	Gout	Multiple Sclerosis	Scarlet Fever	
Cancer	Heart Disease	Mumps	Stroke	

Posture

Do you wear corrective lenses?	Yes No	If Yes, for what condition? Last visit to your optometrist:
Do you wear braces, or have you had major corrective dental work done?	Yes No	If Yes,for how long? What type of work? Last visit to your dentist:
Do you wear corrective orthopedic soles?	Yes No	If Yes, for what condition?

For Women

Do you use contraceptives?	Yes No	If Yes, - Mechanical? - Chemical?
Are you pregnant?	Yes No	If Yes, Which Trimester:
Number of Pregnancies:	Number of Miscarriages:	Number of Abortions:
Do you perform regular breast self exams?	Yes No	Last visit to your gynecologist:
Are you menopausal?	Yes No	If Yes, do you take prescription hormones?

Trauma/ Accidents / Surgeries

Date of Trauma/Accident/Surgery:	Circumstances:	Brief Description:

Family History

Please indicate if any of your immediate family suffers or has suffered from any of the following conditions.

Condition	**Family Member(s)**	**Condition**	**Family Member(s)**
Alcoholism Drug Abuse		Parkinson's, Alzheimer's Disease, Depression, Mental Illness	
Allergies, Intolerances Sensitivities		Stroke, High Blood Pressure, Hormonal Imbalance	
Asthma, Bronchitis Pneumonia, Breast Cancer		Other / Cancers (Please List):	
Ulcers, Liver Disease, Colitis, Colon Cancer			
Kidney Disease, Kidney Stones, Prostate Cancer			

Office Policy and Consent to Use Confidential Health Information

Release of Information

All information provided from page 01 to page 04 is true and accurate to the best of my knowledge. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care assignees and/or beneficiaries and other related persons. I acknowledge that my provider may also send thank-you cards for referrals. I understand that ACT does not otherwise sell or share this information without prior consent. I have read and understand this release policy.

Payment Policy

Payment of all services rendered is due at the time of service to ACT, unless other arrangements are made in advance. I have read and understand this payment policy.

Appointment Cancellation Policy

I understand that 24 hours' notice is required when canceling an appointment. I also understand that the full cost of the visit will be charged if I do not cancel 24 hours prior to the appointment. I have read and understand this cancellation policy.

My signature below indicates that I have read the above information and understand the payment and referral policies, and procedures described above.

Name of Patient (Please Print)

Signature of Patient **Date**

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