Patient History
(To Be Completed by Patient if Able)

Name ______________________ **Date** ______________________

Address ______________________ **Age** ______________________

______________________ **Birth Date** ______________________

Phone (Home) ______________________ **Sex** ______________________

(Work) ______________________ **Marital Status** ______________________

(Cell) ______________________ **Number of Children** ______________________

E-Mail Address: ______________________ **Soc Sec #** ______________________

May we include you on our mailing list? ______________________

Nearest Relative ______________________

Relationship ______________________ **Phone #** ______________________

Patient Occupation/Employer ______________________

Referred By ______________________

Family Physician ______________________

Drug Store & Phone ______________________

	Primary	**Secondary**
Ins. Co. Name	______________________	______________________
Address	______________________	______________________
	______________________	______________________
Phone	______________________	______________________
Policy #	______________________	______________________
Group #	______________________	______________________
Subscriber	______________________	______________________
SS #	____________ **Date of Birth** ________	**SS #** ____________ **DOB** ________
Employer	______________________	______________________
Precert Phone #	______________________	______________________

Is this a Workers' Compensation case: ❒ **Yes** ❒ **No** **Date of Injury** ______________________

Patient Signature ______________________ **or Staff Signature** ______________________

Name ____

Reason Patient Is Being Seen ____

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Allergies/Reactions (including Medication/Foods/Dyes/Seasonal/Environmental) ____________________

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MEDICATIONS/DOSE/FREQUENCY

Prescription	**Over the Counter/Herbals**