PATIENT INFORMATION

Today's date: ________________________

Name: ______________________________

E-Mail: _____________________________

Address: ____________________________

City: __________State: ____Zip: ________

Home Phone: ________________________

Cell Phone: __________________________

Sex: M F

Marital Status: _______________________

SS#: ______________________________

Date of Birth: ________________________

Occupation/School: ___________________

Employer Name: _____________________

Address: ____________________________

City: __________State: ____Zip: ________

Business Phone: ______________________

Emergency Contact #: _________________

Relationship to Patient: ________________

Spouse Name: _______________________

Whom may we thank for referring you?
____

ACCIDENT INFORMATION

Is condition due to accident? Y N
Date: ________________________
Type of accident: Auto Work Home Other
To whom have you made report of your accident?
Auto Ins./Employer/Worker Comp./Other
Attorney Name (if applicable):___________
____

INSURANCE INFORMATION

Primary Insurance Co. Name: ___________

Mailing Address: _____________________

City: ___________State: ____Zip: _______

Ins. Co. Phone #: _____________________

Effective Date: _______________________

Policy ID #: _________________________

Group #: ____________________________

Co-Pay $: ___________

Policy Holder's Name: _________________

Address: ____________________________

____

Phone #: ____________________________

Relationship to patient: ________________

Policy Holder's D.O.B.: ________________

Policy Holder's Employer:
____

SECONDARY INSURANCE

Insurance Co. Name: __________________

Address: ____________________________

Phone #: ____________________________

Effective Date: _______________________

Policy #: ______________

Group: _______

Policy Holder Name: __________________

SS#: _______________________________

Policy Holders D.O.B.: ________________

HEALTH HISTORY

What treatment have you already received for your condition? (please circle)

Medications   Surgeries   Physical Therapy   Chiropractic Services   Other _______________

Name and Address of other doctor(s) who have treated you for your condition

____

Date of Last: Physical Exam_____________ Spinal X-Ray_____________ Blood Test_____________

Spinal Exam_______________ Chest X-Ray______________ Urine Test_____________

Dental X-Ray______________ MRI, CT-Scan, Bone Scan__________________________

Circle "Yes" or "No" to indicate if you have had any of the following:

Condition		
AIDS/HIV	Yes	No
Alcoholism	Yes	No
Allergy Shots	Yes	No
Anemia	Yes	No
Anorexia	Yes	No
Append-icitis	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Bleeding Disorders	Yes	No
Breast Lump	Yes	No
Bronchitis	Yes	No
Bulimia	Yes	No
Cancer	Yes	No
Cataracts	Yes	No
Chemical Depend-ency	Yes	No
Chicken Pox	Yes	No
Diabetes	Yes	No
Emphy-sema	Yes	No
Epilepsy	Yes	No
Fractures	Yes	No
Glaucoma	Yes	No
Goiter	Yes	No
Gonorrhea	Yes	No

Condition		
Gout	Yes	No
Heart Disease	Yes	No
Hepatitis	Yes	No
Hernia	Yes	No
Herniated Disk	Yes	No
Herpes	Yes	No
High Chol-sterol	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Measles	Yes	No
Migraines	Yes	No
Mis-Carriage	Yes	No
Mono-nucleosis	Yes	No
Mumps	Yes	No
Multiple Sclerosis	Yes	No
Osteo-porosis	Yes	No
Pacemaker	Yes	No
Parkinsons	Yes	No
Pinched Nerve	Yes	No
Pneumonia	Yes	No
Polio		

Condition		
Problems		
Prosthesis	Yes	No
Psychiatric Care	Yes	No
Rheum. Arthritis	Yes	No
Rheumatic Fever	Yes	No
Scarelet Fever	Yes	No
Stroke	Yes	No
Suicide Attempt	Yes	No
Thyroid Problems	Yes	No
Tonsilitis	Yes	No
Tuberc-ulosis	Yes	No
Tumors/ Growths	Yes	No
Typhoid Fever	Yes	No
Ulcers	Yes	No
Vaginal Infection	Yes	No
Venereal Disease	Yes	No
Whooping Cough	Yes	No
Other	_________	
	_________	

Innovative Wellness Center

220 Forsgate Drive

Jamesburg, NJ 08831

(732) – 656 – 1740

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Yes No   Prostate   Yes No

Circle what applies to you

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day_______
Moderate	Standing	Alcohol	Drinks/Week ____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day _______
Heavy	Heavy Labor	High Stress Level	Reason__________ ________________

Are you pregnant? Yes No Due Date: __________________

Injuries/ Surgeries you have had	Description	Date
Falls	____	______________
Head Injuries	____	______________
Broken Bones	____	______________
Dislocations	____	______________
Surgeries	____	______________

MEDICATIONS **ALLERGIES** **VITAMINS/HERBS/MINERALS**

____
____
____
____
____
____

Pharmacy Name: ____

Pharmacy Phone: (______) - _______ -_____________

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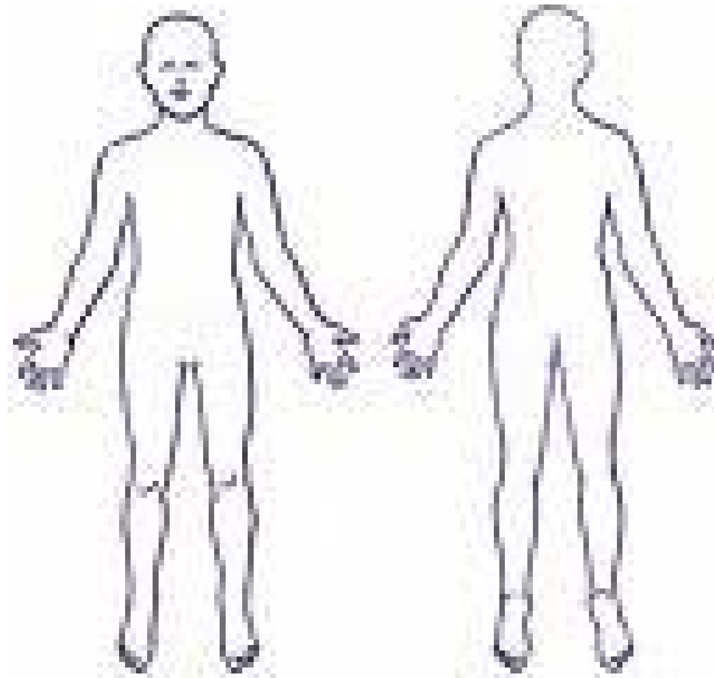
PATIENT CONDITION

Reason for visit: ____
____

When did your symptoms appear? ____
____

Is this condition getting progressively worse? (please circle) Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ________

Is it constant or does it come and go? ____

Does it interfere with your (circle what applies) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking

Bending Lying Down

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