

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:

AIDS/HIV	Yes	No	Gout	Yes	No	Problems		
Alcoholism	Yes	No	Heart			Prosthesis	Yes	No
Allergy	Yes	No	Disease	Yes	No	Psychiatric	Yes	No
Shots			Hepatitis	Yes	No	Care		
Anemia	Yes	No	Hernia	Yes	No	Rheum.	Yes	No
Anorexia	Yes	No	Herniated			Arthritis		
Appendicitis	Yes	No	Disk	Yes	No	Rheumatic	Yes	No
Arthritis	Yes	No	Herpes	Yes	No	Fever		
Asthma	Yes	No	High Chol-			Scarelet	Yes	No
Bleeding	Yes	No	sterol	Yes	No	Fever		
Disorders			Kidney			Stroke	Yes	No
Breast	Yes	No	Disease	Yes	No	Suicide	Yes	No
Lump			Liver			Attempt		
Bronchitis	Yes	No	Disease	Yes	No	Thyroid	Yes	No
Bulimia	Yes	No	Measles	Yes	No	Problems		
Cancer	Yes	No	Migraines	Yes	No	Tonsilitis	Yes	No
Cataracts	Yes	No	Mis-			Tuberc-	Yes	No
Chemical	Yes	No	Carriage	Yes	No	ulosis		
Depend-			Mono-			Tumors/	Yes	No
ency			nucleosis	Yes	No	Growths		
Chicken	Yes	No	Mumps	Yes	No	Typhoid	Yes	No
Pox			Multiple			Fever		
Diabetes	Yes	No	Sclerosis	Yes	No	Ulcers	Yes	No
Emphy-	Yes	No	Osteo-			Vaginal	Yes	No
sema			porosis	Yes	No	Infection		
Epilepsy	Yes	No	Pacemaker	Yes	No	Venereal	Yes	No
Fractures	Yes	No	Parkinsons	Yes	No	Disease		
Glaucoma	Yes	No	Pinched			Whooping	Yes	No
Goiter	Yes	No	Nerve	Yes	No	Cough		
Gonorrhea	Yes	No	Pneumonia	Yes	No	Other		
			Polio				_____	

Innovative Wellness Center

220 Forsgate Drive

Jamesburg, NJ 08831

(732) – 656 – 1740

InnovativeWellnessCenter.com

Yes No

Prostate

Yes No

Circle what applies to you

<u>EXERCISE</u>	<u>WORK ACTIVITY</u>	<u>HABITS</u>	
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: _____

<u>Injuries/ Surgeries you have had</u>	<u>Description</u>	<u>Date</u>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

<u>MEDICATIONS</u>	<u>ALLERGIES</u>	<u>VITAMINS/HERBS/MINERALS</u>

Pharmacy Name: _____
Pharmacy Phone: (_____) - _____ - _____

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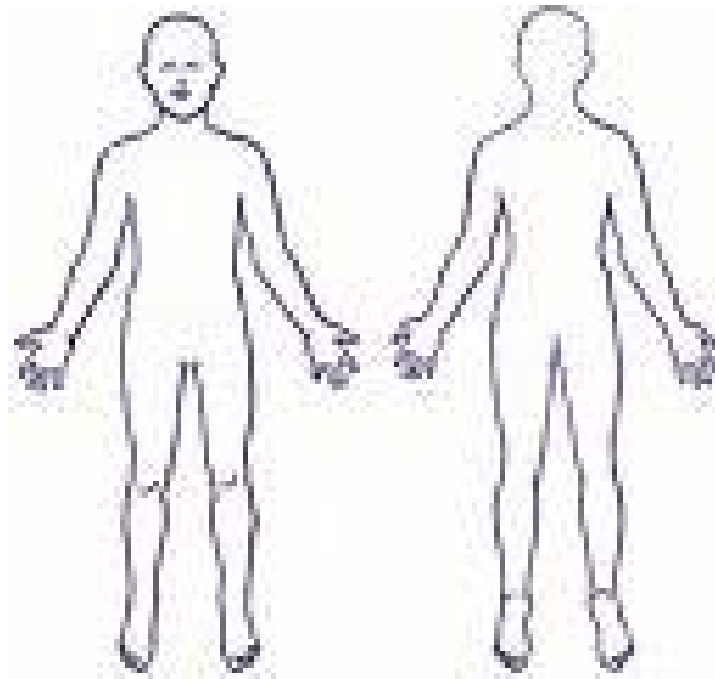
PATIENT CONDITION

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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