

## NEW PATIENT REGISTRATION INFORMATION

Date: \_\_\_\_\_ AcuSport Practitioner: \_\_\_\_\_

Is today's visit because of a work injury? \_\_\_\_\_ Auto Accident? \_\_\_\_\_ Date of Injury: \_\_\_\_\_

### PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Alt Ph: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Domestic Partner: \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBLE PARTY (Please complete if patient is under 18 years old)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Alt Ph: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### REFERRAL INFORMATION (Circle one and specify below)

Patient/Friend/Family    Physician    PCOM    Web-site    Yellow Pages    Other

Name: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Alt Ph: \_\_\_\_\_

Signature: \_\_\_\_\_ Date : \_\_\_\_\_

## MEDICAL HISTORY

Briefly explain your reason for your appointment today: \_\_\_\_\_

\_\_\_\_\_

Have you seen any other health care providers for this condition?  No  Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Past serious illnesses, surgeries or hospitalizations?  No  Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you currently being treated for any health concerns other than your reason for your visit? \_\_\_\_\_

No  Yes, please explain: \_\_\_\_\_

Please list all medications or supplements which you are taking: \_\_\_\_\_

\_\_\_\_\_

If allergy treatment is NOT the reason for your visit, please list any allergies you have: \_\_\_\_\_

\_\_\_\_\_

Do you use tobacco products?  No  Yes      Frequency? \_\_\_\_\_

Do you drink alcoholic beverages?  No  Yes      Frequency? \_\_\_\_\_

Please indicate if you have a past history (circle all that apply):

Headaches

High blood pressure

Bleeding disorders

Heart problems

Lung problems

Hearing problems

Ulcers

Reproductive disorders

Psychiatric problems

Frequent infection/illness

Bad scarring

Street drugs

Thyroid problems

Circulatory problems

Emotional problems

Comments: \_\_\_\_\_

\_\_\_\_\_