NEW PATIENT FORM

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information.

Date: _____

Patient Information:

Name:

_____

(FIRST) (LAST) (M.I.)

Name of parent/guardian (if under 18 years):

_____

(FIRST) (LAST) (M.I.)

Date of Birth :_____ Sex: Male Female

Address: _____Town:_____Zip:_____

Occupation: _____ SS#: _____

Employer: _____

Email:_____

Home Phone: _____ May we leave a message?: Y N

Cell Phone: _____ May we leave a message?: Y N

Work Phone: _____ May we leave a message? Y N

Height: _____ Weight:_____

Last Physical:_____

Primary Care Physician: _____

Phone: _____ Town: _____

Referred by (if any): _____

Emergency Contact Information:

Name: _____

Relation: _____

Emergency Phone: _____

Assignment/Release:

I, the undersigned, certify that I (or my dependent) have insurance with _____. I authorize direct payment to Dr. James Wolf for any insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims.

Signature: _____ Date: _____

Turn to next page ————>>>>

Reason for Visit:

My injury is related to: (circle)

Work Sports Auto Trauma Chronic Unknown

My injury is located : _____

When did this injury/episode begin?_____

Is the pain getting in the way of your: Work Sleep Daily Life

If yes, please describe how it interferes: _____

_____

Please circle words that describe your pain: (circle)

Burning Diffuse Dull Aching Localized Numb

Sharp Radiating Tightness Shooting Stabbing Throbbing

On a scale from 1 (no pain) to 10 (admitted into the hospital), what would your pain be rated when you are:

At your best: _____ At your worst: _____ Currently: _____

What tests have you had done and when were they performed?

X-rays - date/location: _____ CT Scan - date/location: _____

MRI - date/location: _____ EMG/NVC - date/location: _____

Other (please explain): _____

Females Only --- Could you be pregnant? Y N

Any other information that you think would help us: _____

_____

_____

_____

If your insurance plan does not cover your treatment plan, would you be willing to pay out of pocket to alleviate this condition? Y N

Prior Medical History

Have you had any of the following health problems? Please circle all that apply.

High blood pressure Diabetes or high blood sugar Kidney disease Aneurysm

Angina or chest pain Heart attack Liver Disease Asthma

Chronic Cough Arthritis Seizure or Epilepsy TIA/Stroke

Fracture Osteoporosis/Osteopenia Bleeding problem Pacemaker

Cancer: **please specify what type and year** _____

Other: **please specify** _____

_____

Past Surgical History

Approximate Date	Hospital	Type of Operation

MEDICATIONS

MED NAME	REASON	AMOUNT	HOW OFTEN

Please list your HEIGHT and WEIGHT needed to calculate BODY MASS INDEX as per Medicare guidelines: _____ _____

Patient Name: _____ Signature: _____

Date: _____

FAMILY HISTORY

Mother

Father

Siblings

Other

REVIEW OF SYSTEMS

Constitutional
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Insomnia
- ☐ Fever

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Swelling of the feet or ankles

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in the stool

Neurological
- ☐ Frequent headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury
- ☐ Memory loss
- ☐ Fainting
- ☐ Poor balance

Eyes
- ☐ Eye disease
- ☐ Glasses or contacts
- ☐ Blurred or double vision
- ☐ Vision loss

Genitourinary
- ☐ Frequent urination
- ☐ Urgency of urination
- ☐ Painful urination
- ☐ Incontinence
- ☐ Sexual difficulty
- ☐ Kidney stones

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Swollen glands in the neck

Hematological
- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Recurrent infections

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Hallucination

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty walking

Endocrine
- ☐ Excessive thirst
- ☐ Heat or cold intolerance
- ☐ Glandular or hormone problems

Skin
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
