PERSONAL DATA

Date _____ Patient's Social Security No. _____

Patient's Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Phones: Home _____ Cell _____

Work _____ Email _____

Check if you are: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated; Ages of Children _____

Name of Spouse _____ Spouse's Date of Birth _____

Employer _____ Spouse's Employer _____

If under 18, Parent/Legal Guardian Name _____

Parent/Guardian's Signature for Consent to Treat _____

Referred to this Office by _____

Family Physician _____ Date of Last Visit _____

Address _____

PLEASE CHECK TYPE OF INSURANCE YOU HAVE

❑ Cigna _____ ❑ MVP _____

❑ BCBS No. _____ ❑ NYS No Fault _____

❑ Excellus _____ ❑ Medicare No. _____

❑ Medicare Blue Choice _____ ❑ Workers Compensation _____

❑ Aetna _____ ❑ Other _____

❑ United Health Care _____ ❑ _____

MEDICAL HISTORY

GENERAL DATA:

Height _____ Weight _____ ❑ Right Handed ❑ Left Handed

Occupation - Describe your activities at work

❑ Assembly/Factory ❑ Other _____

❑ Construction ❑ Computers

❑ Heavy Repetitive Bending/Lifting ❑ Clerical/Desk Work

When did pain first occur? _____

How did it happen? _____

Have you had this problem before? _____