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NEW PATIENT INFORMATION FORM

NAME: _____ DOB: _____ AGE: _____ GENDER: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL #: _____ SSN: _____ STATUS: M W D S

HOME PHONE #: _____ WORK #: _____ EMAIL: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ CHILDREN (How many): _____

OCCUPATION: _____ EMPLOYER: _____

CHIEF COMPLAIN (What brings you to our office?): _____

_____

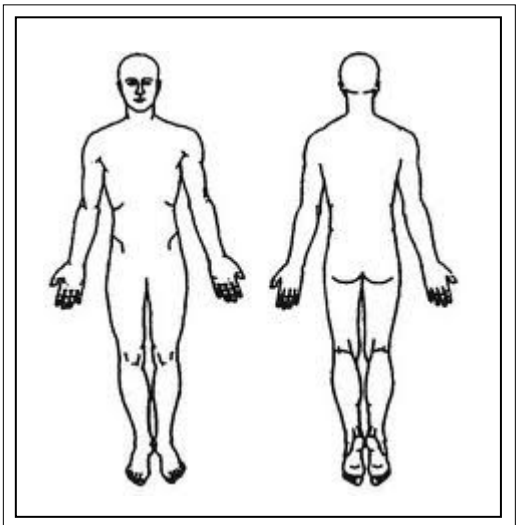
_____

_____

_____

_____

_____



On The Pain Drawing above please place a circle on each area where you experience symptoms. Make sure to include all areas.

HOW BAD IS YOUR PAIN? (Please Circle a Number)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

HOW OFTEN ARE YOUR SYMPTOMS PRESENT?

❑ 0 to 25% ❑ 26 to 50% ❑ 51 to 75% ❑ 76 to 100%

PLEASE CHECK OFF ALL ACTIVITIES THAT ARE AFFECTED BY YOUR CONDITION (s):

❑ sleep ❑ sitting ❑ standing ❑ walking ❑ lifting ❑ bending ❑ stooping ❑ squatting ❑ putting on shoes and socks
❑ grasping ❑ mouse usage ❑ keystroking ❑ chopping vegetables ❑ cooking ❑ cleaning ❑ vacuuming ❑ reaching ❑ pulling
❑ Any other restricted activities (please list): _____

MEDICAL HISTORY

Have you been treated for any conditions in the last year? ❑ yes ❑ no

If yes, please describe: _____

Date of last physical examination: _____ Is there a chance you are pregnant? ❑ yes ❑ no

Have you had x-rays taken? ❑ yes ❑ no If yes, what body part and when? _____

What medications are you taking and for what conditions? (Please list dosage and amount etc.): _____

_____

What vitamins, minerals or herbs do you currently take? _____

HAVE YOU EVER:	**YES**	**NO**	**BRIEFLY EXPLAIN**
Broken bones?	❑ yes	❑ no	_____
Been Hospitalized?	❑ yes	❑ no	_____
Been in an auto accident?	❑ yes	❑ no	_____
Had sprains /strains?	❑ yes	❑ no	_____
Been struck unconscious?	❑ yes	❑ no	_____
Had surgery?	❑ yes	❑ no	_____

PATIENT SIGNATURE: _____ DATE: _____ (Please turn over to complete)

Patient's Name: _____ Date: _____

PLEASE CHECK ALL THE FOLLOWING THAT APPLIES TO YOU: ❑ **NONE APPLY**

❑ Recent infection: _____ ❑ Recent fever ❑ HIV/AIDS

❑ Diabetes: Medication (Rx): _____ ❑ Corticosteroid use ❑ Birth control pills

❑ High blood pressure: (Rx): _____ ❑ Stroke: Date: _____ ❑ Dizziness/fainting

❑ Numbness / pain in groin / buttocks ❑ Urinary retention ❑ Osteoporosis

❑ Aortic aneurysm: Date: _____ ❑ Cancer / Tumor: Date: _____ ❑ Prostate problems

❑ Thyroid: (Rx): _____ ❑ Recent trauma: Date: _____ ❑ Frequent urination

❑ Abnormal weight: ❑ gain ❑ loss ❑ Epilepsy / seizures ❑ Arthritis

❑ Heart burn / Indigestion / Stomach aches / Cramps / Nausea / Queasy / Bloating / Belching / Gas / Ulcer / Hiatal hernia

❑ Headaches: Base of skull / Temples / Crown of head / TMJ / Sinus / Migraine

❑ Sleep: ❑ Difficulty falling asleep ❑ Difficulty staying asleep ❑ Insomnia ❑ Sleep cravings ❑ Jolts / dreams / nightmares

❑ Mood: Anxiety / Sad / Grief / Moodiness / Irritability / Worrisome / Nervous / Frustrated / Panic / Cry / Fears / Stress / Guilt

❑ Bowels: Regular / Incomplete evacuation / Sluggish, move every ___ days / Cramps / Laxative use / Enemas / Colonics

❑ Fecal Consistency: Soft / Ribbons / Mucous / Normal (like thick toothpaste) / Hard / Pebbles / Dry / Painful / Diarrhea / Constipation

❑ Bladder: Nocturnal—times you go at night _____ / Weak stream / Frequency / Urgency / Burn / Odor / Spasm / Leak / UTI

❑ History of low back pain ❑ Yes ❑ No. If yes, when: _____

❑ History of neck pain ❑ Yes ❑ No. If yes, when: _____

HABITS:	**NONE**	**LIGHT**	**MEDIUM**	**HEAVY**
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty foods	❑	❑	❑	❑
Sugary foods	❑	❑	❑	❑
Artificial sweetners	❑	❑	❑	❑

FAMILY HISTORY:

❑ Cancer
❑ Diabetes
❑ High blood pressure
❑ Cardiovascular (heart attack, stroke, etc).

I certify the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate or if I'm not eligible to receive a healthcare benefits through this provider I understand that I am liable for all charges for services rendered. I agree to notify Dr. Tereo and his staff whenever I have a change in my health condition in the future or of any changes to my mailing address, phone number or email address.

PATIENT'S SIGNATURE: _____ DATE: _____