

NEW PATIENT REGISTRATION

DATE: ____/____/____

PATIENT INFORMATION

Patient Name:					DOB:				
Marital Status: Single Married Divorced Widowed Other					Primary Language: English Other:				
Race*: Native Am./or Alaskan Native Asian African Am./or Black Hispanic/or Latino Native Hawaiian/or Pacific Isl. White Withheld									
Ethnicity*: Non-Hispanic/Non-Latino Hispanic/or Latino Withheld							*Government Requirement		
SSN:			Occupation:				Employer:		
Current address:									
Home#				Cell#			Carrier	Work#	
Email:					Referred by:				
Preferred Method of Communication: Phone -Home Phone -Cell Phone-Work Email									
Primary Care Physician:					Phone:				
Emergency Contact/Auth. Med.Release:					Phone:				
Contact/Release Relationship to patient: Spouse Parent Guardian Sibling Other:									
List any persons you explicitly prohibit from disclosure of information:									

INSURANCE INFORMATION

Insurance Co. Name:									
ID #:					Group #:				
Relationship to Policy Holder: Self Spouse Parent Other					If you circled SELF move on to Current Condition				
Policy Holder's Name:					Phone#:				
Policy Holder's DOB:				Policy Holder's Employer:					
Does the Policy Holder have a different address from the patient? No Yes If yes, please add it below.									
Policy Holder's Address:									

CURRENT CONDITION (PLEASE LIST IN ORDER OF SEVERAITY)

AREA OF INJURY/CONDITION	WHEN DID YOUR SYMPTOMS BEGIN?						
1.)	____/____/____		Gradual	Chronic	Just came on	Sports Injury	
Location:	Left	Right	Bilateral	Slip/Fall	Work Injury	Auto Accident	Other
Symptoms worse:	Morning	Afternoon	Evening	Night	Sleep	With Activity	Other:
Unable to:	Sit	Stand	Walk	Bend	Lift	Lie	Other:
Symptom frequency:	Constant	Come & Go	Other:				

Continue -->

2.)		____/____/____		Gradual		Chronic		Just came on		Sports Injury					
Location:		Left		Right		Bilateral		Slip/Fall		Work Injury		Auto Accident		Other	
Symptoms worse:		Morning		Afternoon		Evening		Night		Sleep		With Activity		Other:	
Unable to:		Sit		Stand		Walk		Bend		Lift		Lie		Other:	
Symptom frequency:		Constant		Come & Go		Other:									

3.)		____/____/____		Gradual		Chronic		Just came on		Sports Injury					
Location:		Left		Right		Bilateral		Slip/Fall		Work Injury		Auto Accident		Other	
Symptoms worse:		Morning		Afternoon		Evening		Night		Sleep		With Activity		Other:	
Unable to:		Sit		Stand		Walk		Bend		Lift		Lie		Other:	
Symptom frequency:		Constant		Come & Go		Other:									

4.)		____/____/____		Gradual		Chronic		Just came on		Sports Injury					
Location:		Left		Right		Bilateral		Slip/Fall		Work Injury		Auto Accident		Other	
Symptoms worse:		Morning		Afternoon		Evening		Night		Sleep		With Activity		Other:	
Unable to:		Sit		Stand		Walk		Bend		Lift		Lie		Other:	
Symptom frequency:		Constant		Come & Go		Other:									

QUESTIONS REGARDING YOUR PAIN

Does your pain interfere with:		Normal Daily Activities		Driving		Exercising		Sleep		Work		Other:	
Have you treated with any other health care provider for these complaints?				Yes		No		If yes, please list treatments & outcomes:					

CURRENT PATIENT HISTORY

1.	Current tobacco use	Never		Lives with smoker		Former : ____ years quit		Light: ____ years smoked		Every day: ____ years smoked							
		Heavy: ____ years smoked				Type of tobacco use		Cigarette		Cigar		Pipe		Chew		Dip	
2.	Do you have dietary restrictions?	Yes		No		If yes:											
3.	How frequently do you exercise?	Never		Avoids due to pain		Limited		Infrequent		Occasional		Regular		Frequent			
4.	Current alcohol use	Never		Rarely		Socially		Moderately		Frequently		Heavily		Recovering Alcoholic : _____ # of years			
5.	List any over-the-counter drugs, vitamins, supplements you are currently taking:																
6.	List all prescribed medications and dosage that you are currently taking:																
7.	Do you have any allergies, medical or non-medical:	Yes		No		If yes:											
8.	Do you have a pace maker or any other device that could impede treatment?	Yes		No		If yes:											

PAST PATIENT HISTORY

1.	List any serious accidents, illnesses, surgeries, or fractures along with approx. date:
	___/___/___ : _____ ___/___/___ : _____
	___/___/___ : _____ ___/___/___ : _____
2.	List any illnesses/conditions that you have been diagnosed with:
3.	Circle any childhood illnesses/diseases you've had: Mumps Measles Chicken Pox Polio Other:

IMMEDIATE FAMILY HEALTH HISTORY

List any serious health problems that affect any of your immediate family members

1.	Mother:	2.	Father:
3.	Sibling(s):		
3.	Other Relative(s):		

(Optional) Add additional information pertaining to your condition

By signing this form I am authorizing that to the best of my knowledge I have provided Dr. Malcolm Conway with an accurate and complete representation of my medical history and current conditions.

Signature of patient (or guardian):	Date:
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