INSTITUTE
FOR PHYSICAL & ALTERNATIVE MEDICINE, P.A.

NEW PATIENT FORM

Name_____Date of Birth_____Age_____
Address_____ Phone_____Cell Phone_____
City_____State_____Zip_____Email_____
What is the best way to reach you?_____
Who is your primary doctor?_____ Phone/FAX_____
Contact in case of an emergency?_____Phone_____
Referred By?_____
Primary Insurance Company_____
Secondary Insurance Company_____
Employer_____ Work Phone_____
Name of the primary person insured?_____Date of Birth_____ Soc. Sec.#_____
Name of the other person insured?_____Date of Birth_____ Soc. Sec.#_____
Marital Status: ☐Married ☐Single

YOUR MAIN PROBLEM

What problem is bothering you the most?_____

_____

Severity:	**Frequency:**	**Duration**:	**Description of problem at its worst:**	
☐Very Severe	☐Constant	☐Less than 3 weeks	☐Can't Stand it	☐Bothers me often
☐Severe	☐Frequent	☐3 weeks to 3 months	☐Annoying	☐Can't Sleep
☐Moderate	☐Occasional	☐Over 3 Months	☐Puts me in bed	☐Makes it hard to do things
☐Mild	☐Off & On		Other_____	

How does this problem affect your lifestyle?_____

Accidental Origin? Was this problem caused by an accident? ☐ Yes ☐No
If the problem was caused by an accident within the last 6 months, was the injury...? ☐Automobile Related
☐Work Related ☐ Occurred at Home ☐Recreational Other_____

No Accident: If the problem is not accident related, what do you think brought it on?
☐Stress ☐Over-doing it ☐**Nothing really**, it just started ☐Don't Know Other_____

Any other details that are important:_____

_____

PLEASE CIRCLE OTHER PROBLEMS YOU CURRENTLY HAVE

Musculoskeletal	**General**	**Nervous System**	**Gastrointestinal**	**Cardiovascular**
Low Back Pain	Fatigue	Pinched nerve	Abdominal Pain	Chest Pain
Neck Pain	Loss of Sleep	Neuropathy	Diarrhea	Shortness of Breath
Pain between shoulders	Diabetes	Numbness	Indigestion	High Blood Pressure
Arm pain	Frequent Ill	Fainting	Gas/Bloating	Heart Problems
Joint Problems	Skin Condition	Tingling	Constipation	Irregular Heart Beat
Walking Problems	HIV Positive	Burning	Heartburn	Chest Pain
Jaw Disorder	Allergies	Weakness	Liver trouble	Varicose Veins
Hip disorder	**Cancer**	Convulsions	Gall Bladder	Ankle Swelling
Leg Pain	Thyroid	Anxiety	Crohn's	Cold Hands or Feet
Sciatica	Hormonal	Forgetful	Irritable Bowel	**Urinary**
Disc problem	**Respiratory**	Cloudy Thinking	Hemorrhoids	Bladder Trouble
Knee Problems	Asthma	Dizziness	Ulcer	Frequent Urination
Foot Pain	COPD	Stroke	Vomiting	Urinary Infection
Headaches	Cough	Depression	Colitis	Kidney Disease
Arthritis	Breathing Difficulty		GERD/Reflux	Kidney stones

PLEASE CHECK HEALTH PROBLEMS YOU HAVE HAD IN THE PAST

☐Allergy	☐Cardiovascular	☐Gout	☐Pneumonia	☐Ulcers
☐Anemia	☐Chorea	☐Heart Disease	☐Polio	☐Whooping Cough
☐Appendicitis	☐Cold Sores	☐Influenza	☐Prostate	☐Venereal Disease
☐Arteriosclerosis	☐Diabetes	☐Joint Problems	☐Rheumatic Fever	OTHERS:
☐Arthritis	☐Disc Problems	☐Kidney Disease	☐Rheumatism	
☐Asthma	☐Diphtheria	☐Mental Illness	☐Seizures	_____
☐Back Pain	☐Emphysema/COPD	☐Measles/Mumps	☐Skin Disorder	
☐Blood Pressure	☐Endometriosis	☐Miscarriage	☐Stroke	_____
☐Broken Bone	☐HIV	☐Multiple Sclerosis	☐Substance Abuse	
☐**Cancer**	☐Hepatitis	☐Pleurisy/Lung Prob.	☐Tuberculosis	_____

HABITS

SMOKING ☐ Never _____Packs per day for _____years
ALCOHOL ☐ Never ☐occasionally ☐Weekly ☐Daily
ASPARTAME ☐ Never ☐occasionally ☐Weekly ☐Daily
JUNK FOOD ☐ Never ☐occasionally ☐Moderately ☐ Excessive

DIETING ☐ Never ☐occasionally ☐ Frequently ☐ Constantly
EXERCISE ☐ Never ☐occasionally ☐Moderately ☐ Heavy
VITAMINS ☐ Never ☐Sometimes ☐Consistently ☐Daily
SPORTS ☐ Never ☐occasionally ☐Moderately ☐ Heavy

FAMILY HISTORY

Please check any conditions that a family member has suffered from:

☐**CANCER** ☐STROKE ☐HEART DISEASE ☐ COLITIS ☐ ASTHMA ☐AUTOIMMUNE DISEASE
☐DIABETES ☐NEUROLOGICAL DISEASE ☐KIDNEY STONES/DISEASE ☐ HIGH BLOOD PRESSURE

MEDICAL

Current Medications: ***Please check all that apply.***

☐Pain Medication	☐Anti-Inflammatory	☐Muscle Relaxers	☐Anti-Depressants	☐Blood Pressure
☐Allergy	☐Antibiotics	☐Anxiety Medication	☐Birth Control	☐Hormones
☐Heartburn Med.	☐**Blood Thinners**	☐Cholesterol Medicine	☐Heart Medicine	☐Arthritis Med.

OTHER MEDICATIONS:_____

SURGERIES:_____

FALLS or MAJOR INJURIES:_____

SCARS & THEIR LOCATIONS:_____

I give my full consent and authorize the doctors and staff to treat me as they believe is necessary to improve my condition. I further authorize the clinic personnel to refer information in my case to other professionals if necessary.
I certify that all of the information given is true and correct. I also certify that I am here for the sole purpose of getting better and no other reason.

Patient Signature_____ **DATE**_____

INSURANCE AUTHORIZATION & ASSIGNMENT
(Please sign if insurance is to be filed.)

I authorize direct payment to this clinic of any sum I owe; by any insurance company or third party obligated to reimburse for the charges for clinic services. However, I understand and agree that if the insurance company does not pay within 90 days, I remain fully obligated to pay whatever sums the insurance company does not pay.

Patient Signature_____ **DATE**_____