Patient Information Sheet

Today's Date:

***Name** ***Birthdate:**

***Address**

***City** **State** **ZIP**

***Home Phone:**

Cell Phone:

***Email address:**

***Ethnicity:** **Caucasian** **Hispanic** **African- American** **Asian** **Decline to Specify**

***Language Preference:** **English** **Spanish** **Polish** **Other:**

***Contact Preference:** **Home Address** **Phone** **Email**

Spouse Name:

Spouse Phone Number:

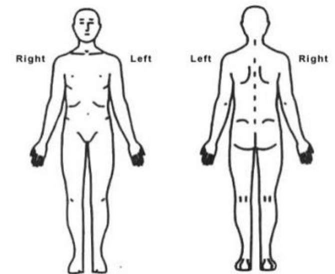
Emergency contact (if different that Spouse):

Phone Number:

How did you hear about CHPT?

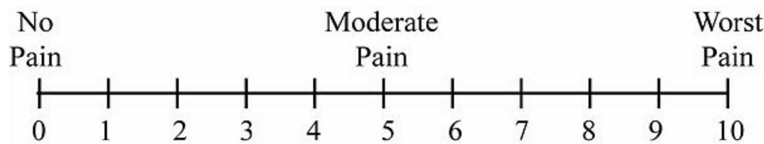
***What is the primary reason for your visit today?**

Mark Areas of Pain with an X:



When did your symptoms begin?

Pain Levels: Please indicate on the scale how much pain you have right now.



***Medications: Please list any medications that you are taking on a daily basis:**

***Any known allergies?**

***Smoking Status:** Never Smoked Used to Smoke Currently Smoking

***Medical Conditions (circle all that apply to you):**

Cancer	Stroke	Pacemaker
Heart Problems	Epilepsy/Seizures	Emphysema/Chronic Bronchitis
High Blood Pressure	Multiple Sclerosis	Asthma
Ankle Swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low Back Pain	Fatigue	Headaches
Sacroiliac/Tailbone Pain	Fibromyalgia	Diabetes
Alcoholism/Drug Abuse	Arthritis	Kidney Disease
Childhood Bladder Problems		Irritable Bowel Syndrome
Depression	Joint Replacement	Hepatitis HIV/AIDS
Anorexia/Bulimia	Bone Fracture	STD
Smoking History	Sports Injuries	Physical or Sexual Abuse
Vision/Eye Problems	TMJ/Neck Pain	Raynaud's
Hearing Loss/Problems	Rheumatoid Arthritis	Pelvic Pain
Other		______________________

***Surgeries:**

Appendectomy	Carpal Tunnel	Hysterectomy	
Joint Replacement	Prostate	Gall Bladder	
Brain	Shoulder	Knee	
Heart	Gastrointestinal	Hernia	Other: ______________

Is there anything else that the doctors should know about your health and health history?

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HIPPA Policies Acknowledgement

Please read ***HIPPA Notice*** Attached to Clipboard.

I have reviewed CHPT HIPPA Policies.

Initials: **Date:**

CHPT Financial Policy Acknowledgement

Please read the CHPT Financial Policy Attached to the Clipboard.

I have reviewed and understand my financial obligations as a patient at CHPT.

Initials: **Date:**

Thank you for taking the time to fill out this form. The doctor will use this information to help create an individualized plan of care.

For Staff to Fill Out

*Height ______________ inches

*Weight ______________ pounds

*Blood Pressure