(Please Print)

PATIENT INFORMATION

Today's date:		Primary Care Physician:		
Patient's Name (Last, First, Middle):		☐ Mr. ☐ Miss. ☐ Mrs. ☐ Ms.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birthdate (mm/dd/yyyy):	Age: Sex: ☐ M ☐ F
Your Social Security Number:	Spouse/Significant other's name:	Email:		
Street address: Check if P.O. Box ☐	City, State, ZIP:	Home Phone: Cell Phone:		
Occupation:	Employer:	Employer Phone:		

How you heard about us (check one):

☐ Dr. Referral ☐ Family/Friend ☐ Hospital ☐ Mailer ☐ Newspaper
☐ TV Infomercial ☐ TV Advertisement ☐ Dinner Event ☐ Other ______________

Please List any other family members/friends involved in your health decisions:

Insurance Name:	☐ PPO ☐ HMO ☐ Other ______________________________

IN CASE OF EMERGENCY, WHO DO WE CONTACT? (Local friend or relative)

Name:	Relationship to patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge.

Patient/Guardian Signature: Date:

Patient Name: ______________________________ **Today's Date:** __________

What is your major complaint?

____

____

____

How long have you had this problem?

____

____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? If yes, please describe:

____

____

____

What have you tried for treatment that did not work?

____

____

____

Have you seen a M.D., P.T., or a D.C. for this problem? ☐ **Yes** ☐ **No**

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

____

____

____

Have you been worried about getting this problem resolved? If yes, please describe:

____

____

____

What is your main concern about your symptoms?

____

____

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

1	2	3	4	5	6	7	8	9	10

Personal History

Patient Name: ________________________________ **Today's Date:** ___________

General
- ☐ Fatigue/tiredness
- ☐ Weakness
- ☐ Chills
- ☐ Fever
- ☐ Night sweat
- ☐ Appetite change
- ☐ Lived in foreign country
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Generalized pain
- ☐ Unable to tolerate heat
- ☐ Unable to tolerate cold
- ☐ Sedentary lifestyle
- ☐ Active lifestyle
- ☐ Other _______________

Neurological
- ☐ Fainting spells
- ☐ Seizures
- ☐ Paralysis
- ☐ Dizziness
- ☐ Tremor
- ☐ Chronic headaches
- ☐ Poor balance
- ☐ Fractured back or neck
- ☐ Numbness of face/arm/leg
- ☐ Peripheral neuropathy
- ☐ Stroke or Mini – stroke
- ☐ Other _______________

Psychiatric
- ☐ Depression
- ☐ Anxiety (abnormal)
- ☐ Panic attacks
- ☐ Alzheimer's
- ☐ Confusion (abnormal)
- ☐ Hospitalized for nervousness
- ☐ Substance abuse
- ☐ Anorexia
- ☐ Other _______________

Respiratory
- ☐ COPD
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Tuberculosis (TB)
- ☐ Lung Cancer
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Pneumonia
- ☐ Fluid in lungs
- ☐ Need to sleep sitting up
- ☐ Other _______________

Skin
- ☐ Rashes
- ☐ Tumors
- ☐ Sensitivity to sunlight
- ☐ Malignant melanoma
- ☐ Squamous cell carcinoma
- ☐ Basal cell carcinoma
- ☐ Bruises easily
- ☐ Fungal infection(s)
- ☐ Non-healing sore(s)
- ☐ Very rough or dry skin
- ☐ Other _______________

Vascular
- ☐ Leg pain walking > 1 block
- ☐ Leg pain walking < 1 block
- ☐ Pain in legs while at rest
- ☐ Blood clots in legs:
  - ☐ Deep
  - ☐ Superficial
- ☐ Cold feet or hands
- ☐ Amputation of toes
- ☐ Amputation of feet or legs
- ☐ Peripheral vascular disease
- ☐ Ulcers of lower legs
- ☐ Varicose veins
- ☐ Aneurysm of arteries
- ☐ Other _______________

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stool changes
- ☐ Bowel habits changes
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Colon polyps
- ☐ Cramps/ pains
- ☐ Cancer: Bowel or stomach
- ☐ Diverticulitis
- ☐ Other _______________

Genitourinary
- ☐ Hesitancy/urgency of urine
- ☐ Frequent urination at night
- ☐ Loss of bladder control
- ☐ Difficult urination
- ☐ Renal failure
- ☐ Impotence
- ☐ Current Dialysis
- ☐ Renal transplant
- ☐ Prostate enlargement
- ☐ Bladder or kidney cancer
- ☐ Other _______________

Blood & Lymph System
- ☐ Anemia
- ☐ Blood disease
- ☐ Have had blood transfusions
- ☐ Leukemia
- ☐ Have had bone marrow test
- ☐ Long-term Coumadin use
- ☐ Blood clotting problems
- ☐ Other _______________

Eyes, ears, nose & throat
- ☐ Pain
- ☐ Hearing loss
- ☐ Polyps
- ☐ Vertigo
- ☐ Ringing in ears (tinnitus)
- ☐ Sinus infections
- ☐ Deafness
- ☐ Other _______________

Musculoskeletal
- ☐ Arthritis
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Leg cramps
- ☐ Other _______________

Cardiac
- ☐ Angina (chest pain)
- ☐ Rapid heartbeat
- ☐ Past heart attacks
- ☐ Heart murmur
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Aortic aneurysm
- ☐ **Pacemaker**
- ☐ **Defibrillator**
- ☐ Other _______________

Endocrine
- ☐ Thyroid problems
- ☐ **Diabetes – Type 1**
- ☐ **Diabetes – Type 2**

Abnormal Organs
- ☐ Hepatitis
- ☐ Cirrhosis of the liver
- ☐ Gallbladder disease

Misc data
Height: ______________________________

Weight: ______________________________

FRONTIER
PHYSICAL MEDICINE

Medication List

Note: Please fill in the below form as best as you can. If you are taking medications for Neuropathy symptoms or for other situations you're here to address, make sure to at least note these.

Your name: ______________________ Date of Birth: ____________ Today's date: ____________

Name of Medication	Dosage	How often you take it