Patient Information:

Name: _____ Date of Birth: _____ /_____ /_____

Gender: ☐Male ☐Female Social Security #: _____-_____-_____

E-mail Address: _____

Vocation: _____

☐Full Time ☐Part Time ☐Student ☐Homemaker ☐Unemployed ☐Disability ☐Retired

Driver License #: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: Work Address:

_____ _____

_____ _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Medical History:

Please check all that apply:

☐Your condition is a result of an accident from employment.

☐Your condition is a result of an auto accident.

☐Your condition is a result of any other type of accident.

Accident:

Date of accident/injury: _____ /_____ /_____ State accident occurred: _____

Type of accident: _____

_____

Amputation only: Is your amputation congenital (since birth)? ☐Yes ☐No

Have you had or do you have any of the following:

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems	☐ Pacemaker/Defibrillator
☐ Hypertension	☐ Hepatitis C	☐ Parkinson Disease	☐ Seizure Disorder
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease	☐ Hearing Loss
☐ Stroke	☐ Rheumatoid Arth.	☐ Psych. Problems	☐ Currently Pregnant
☐ Diabetes	☐ Obesity	☐ Alcoholism	☐ MRSA
☐ Kidney Disease	☐ Osteoarthritis	☐ Known Allergies (including contact materials)	
☐ Osteoporosis	☐ Pulmonary Disease (TB)		

List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries): _____

_____

_____

_____

Medications:

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____