NORTH ALABAMA SPINE AND REHAB

NEW PATIENT INFORMATION

For Office use only
Patient #

Date _____________

Patient's First Name_____________________ Middle_________ Last___________________________

Address _________________________________ City ____________________ Zip Code ___________

Home Phone ______________________________ Cell Phone_______________________________

E-mail ____ Social Security # ______________________

Employer Name ____

Job Title ____ Work Phone # ___________________

Date of Birth ___________ Age____ Gender ☐ Male ☐ Female Handedness? R L

Weight___________ Height __________ Marital Status S M W D

Spouse's Name________________________________ Spouse's Date of Birth __________________

In case of an emergency who should we contact?____

Phone #____

Person responsible for this account____

PRESENT HEALTH

Please list any medications you are currently taking? ______________________________________

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____

Have you received any medical treatment since your accident? Y N

Hospital____

When?(Days/Weeks/Months/Years)____

Medical Doctor____

When? (Days/Weeks/Months/Years) ____

Chiropractor____

When? (Days/Weeks/Months/Years) ____

Physical Therapy____

When? (Days/Weeks/Months/Years)____

Other____

When? (Days/Weeks/Months/Years) ____

MEDICAL HISTORY

As a child, did you have any of the following diseases?

☐ Scarlet fever ☐ Rheumatic fever ☐ Diphtheria ☐ Mumps ☐ Measles

☐ German measles ☐ Other:____

____

List any hospitalizations or surgeries you had with corresponding dates?____________________

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Have you ever been in a prior auto accident? ____________ When?__________________________

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Were you treated for injuries and what type of injuries? __________________________________

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List other injuries including falls and other traumas and when they occurred: ___________________

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Have you been diagnosed with any diseases or disorders and when? _________________________

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