PREMIER HEALTH & REHAB SOLUTIONS

Full Name _____ ❑ Male ❑ Female

Date of Birth_____ Social Security Number _____-_____-_____

Address _____ Apt # _____

City _____ ST_____ Zip _____

Phone (H) _____(W) _____(Cell) _____

Email Address:_____

Single / Married / Divorced / Widowed Spouse's Name _____

Your Occupation_____ Employer _____

Health Insurance Company _____ Policy Number _____

Policy Holder _____ Policy Holder DOB _____

Relationship to Policy Holder _____

Have you ever been to another doctor for this problem? Y N If Yes, Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment: _____

Type of Treatment or Drugs Prescribed: _____

Name of Treating Physician _____ Dates of Treatment: _____

Type of Treatment or Drugs Prescribed: _____

Is the Condition you are here for today due to any of the following: Worker's Comp / Auto Accident

Please list any other medications or supplements you are taking, not listed above:_____

_____

How were you referred to our office? ❑ Patient _____ ❑ Physician Dr. _____

❑ Insurance Company ❑ Advertisement ❑ Walk-In ❑ Other:

MEDICAL HISTORY

Please check if you have had any of the following:

❑ Diabetes	❑ Cancer	❑ Dizziness
❑ Stroke	❑ Weight Loss – Unintentional	❑ Passing Out or Faintness
❑ Anemia	❑ Change in Bowel habits	❑ Double Vision
❑ Gout	❑ Gall Bladder Conditions	❑ Difficulty Speaking or Swallowing
❑ Epilepsy	❑ High Blood Pressure	❑ Nausea or Vomiting
❑ Polio	❑ Heart Conditions	❑ Kidney Stones
❑ Multiple Sclerosis	❑ Pace Maker	❑ Venereal Disease
❑ Rheumatic Fever	❑ Chest Pain	❑ Rheumatism
❑ HIV / AIDS	❑ Convulsion/Seizures	❑ Arthritis
❑ Tuberculosis	❑ Numbness & Tingling	❑ Mental Illness
❑ Thyroid Disease	❑ Allergies	❑ Other: _____

Please list any surgeries you have had:_____

_____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparents
Cancer	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

PATIENT SIGNATURE _____ DATE _____