210 Fieldale Rd.
Mebane, NC 27302
919-563-6370 Phone
919-563-6371 Fax

WELCOME

PATIENT INFORMATION

Name: ____
Last First MI Name you prefer to be called

Address: ____
Street City State Zip

Mailing Address if Different: ____
Street City State Zip

Home Phone ( )________________ **Work Phone** ( )________________ **Cell Phone** ( )________________

Date of Birth: ____________ **Sex:** ☐**Male** ☐**Female** **Social Security #** Required for Billing ____________________

Marital status: ☐ **Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widowed**

Occupation: ____________________________ **Employer:** ____________________________

Employer's Address: ____
Street City State Zip

Local Emergency Contact: **Name:** ____________________________ **Relation:**____________________

Phone # ( )________________________ **Work/Cell #** ( )____________________

Do you have Children? ☐**Yes** ☐**No** **How many?** ________ **Ages:** ______________

How did you hear about our practice? ☐**Phone Book** ☐**Mail** ☐**Friend/Family (name):** ______________
☐**Other:** ____________________________

INSURANCE INFORMATION

Is your visit result of a work injury or automobile injury: ☐**Yes** ☐ **No** **If Yes**, please inform receptionist at the front desk

Do you have health insurance? ☐**Yes** ☐**No**

Insurance Company's Name:____

Primary card holder's Name (If Not Yours): ______________________ **Relationship**:____________ **Date of Birth**: __________

Do you have a Secondary Insurance? ☐**Yes** ☐**No** **If Yes Insurance Company's Name**: ______________________

Who is your primary care physician? ____

Practice Name & Location: ______________________________________ **Phone #** ( )____________

HEALTH HISTORY

Please Circle if you are currently experiencing any of the following conditions:

▫Neck Pain/Stiffness	▫Pins/Needles in Arms	▫Light Bothers Eyes	▫Sudden Weight Loss	▫Cold Sweats
▫Back Pain/Stiffness	▫Pins/Needles in Legs	▫Depression	▫Loss of Taste	▫Cold Feet
▫Arm/Hand Pain	▫Fatigue	▫Nervousness	▫Memory Loss/Confusion	▫Chest Pain
▫Leg/Knee Pain	▫Sleeping Difficulties	▫Tension	▫Jaw Problems	▫Fever/Chills
▫Headaches	▫Loss of Smell	▫Nausea/Vomiting	▫Constipation/Diarrhea	▫Fainting
▫Dizziness	▫Allergies	▫Stomach Problems	▫Shortness of Breath	▫Night Pain
▫Asthma	▫Visual Changes	▫Cough	▫Bowel/Bladder Changes	▫Itching/Rash
▫Weakness	▫Swelling/Inflammation	▫Bruising/Bleeding	▫Ringing in Ears	▫Sinus Problems

Please Circle if you have ever had any of the following:

▫Aids/HIV	▫Cancer	▫Hepatitis	▫Osteoporosis	▫Stroke
▫Alcoholism	▫Cataracts	▫Hernia	▫Pacemaker	▫Suicide Attempt
▫Allergy Shots	▫Chemical Dependency	▫Herniated Disc	▫Parkinson's Disease	▫Thyroid Problems
▫Anemia	▫ Chicken Pox	▫Herpes	▫Pinched Nerve	▫Tonsillitis
▫Anorexia	▫Diabetes	▫High Cholesterol	▫Pneumonia	▫Tuberculosis
▫Appendicitis	▫Emphysema	▫Kidney Disease	▫Polio	▫Tumors/Growths
▫Arthritis	▫Epilepsy/Seizures	▫Liver Disease	▫Prostate Problems	▫Thyroid Fever
▫Asthma	▫Fractures	▫Measles	▫Prosthesis	▫Ulcers
▫Bleeding Disorders	▫Glaucoma	▫Migraines	▫Psychiatric Care	▫Vaginal Infections
▫Breast Lump	▫Goiter	▫Miscarriage	▫Rheumatoid Arthritis	▫Venereal Disease
▫Bronchitis	▫Gonorrhea	▫Mononucleosis	▫Rheumatic Fever	▫Whooping Cough
▫Bulimia	▫Gout	▫Multiple Sclerosis	▫Scarlet Fever	▫Mumps
▫Heart Disease	▫Other___________________			

Please list any medications you are currently taking (including over the counter medications and vitamins/herbs/minerals):

____

____

Please list any surgeries, hospitalizations, and/or accidents you have had (type & date):

____

____

Please list any allergies: ____

Do you exercise: ☐Frequent ☐Moderate ☐Occasional ☐Never

Tobacco Use: ☐Frequent ☐Moderate ☐Occasional ☐Never

Alcohol Use: ☐Frequent ☐Moderate ☐Occasional ☐Never

Do your work activities involve: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐ Computer Use

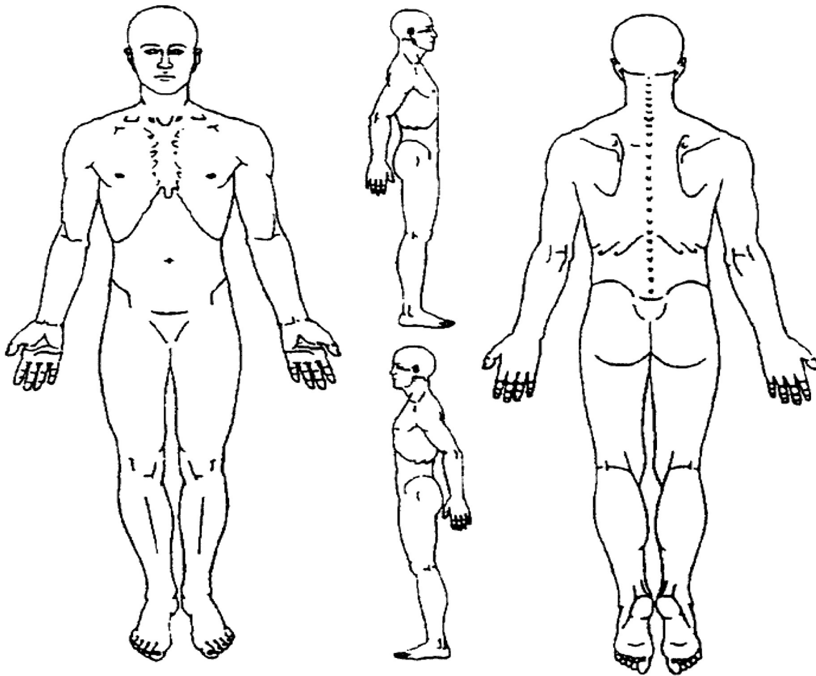
Do you sleep on your: ☐Back ☐Side ☐Stomach Do you use a cervical pillow? ☐Yes ☐No

Family History

Is there a family history of any of the following conditions?

☐Heart Disease _________ ☐Diabetes _________ ☐Cancer _________ ☐Arthritis _________ ☐Other _________

(Indicate family member including parents, grandparents, & siblings)



Please Rate your Pain on a scale of 0-10

(With 10 being the worst possible pain)

Your Pain Now: ________

At its Worst: ________

Place appropriate letter on the diagram:

Ache = **A**
Pins & Needles / Tingling = **TG**
Burning = **B**
Stabbing & Sharp = **S**
Shooting = **SH**
Tight = **T**
Stiff = **ST**
Throbbing = **TH**
Numb = **N**

Reason for your visit? ____

When Did This Begin? ____

What caused the symptoms? ____

What makes the pain better? ____

What makes it worse? ____

Painful movements: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

Is the pain: ☐Constant ☐Comes and Goes ☐Getting Better ☐Getting Worse ☐Same

Does the pain radiate? ☐ No ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Recreational Activities

Do you experience pain at a particular time of the day or night: ________________________

Have you had this or similar conditions in the past? ☐Yes ☐No

If so, please explain:____

Have you seen another healthcare practitioner for the pain/condition? ☐Yes ☐No

If so, Where & When? ____

What was the Treatment? ____

I certify all the above questions were answered accurately:______________________________________ ________

Signed Date