PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ____/_____/_____

PATIENT NAME: _________________ _________________ ____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

HOME ADDRESS: ______________________________________ CITY/STATE: ________________________ ZIP: _____________

HOME PHONE #: (_____) _____-________ E-MAIL: _____________________________________

WORK PHONE #: (_____) _____-________ PRIMARY LANGUAGE: __________________________

CELL PHONE #: (_____) _____-________ RACE/ ETHNICITY:_____________________________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: ____________________________ RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

EMERGENCY CONTACT: ____________________________ RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

PRIMARY CARE DOCTOR: ____ PHONE: __________________________________
PHARMACY: _____________________________ LOCATION: __________________________ PHONE #: (_____) _____-_______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
______ YES NAME(S) ____

______ NO

WHO IS RESPONSIBLE FOR PAYMENT? ______________________________ RELATIONSHIP TO PATIENT? ________________

ADDRESS: ________________________ CITY/STATE: _________________ ZIP: _________ PHONE #: (_____) _____-______

WHO REFERRED YOU TO US?____

MEDICAL HISTORY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: [ ] SINGLE [ ]MARRIED [ ]PARTNERED [ ]SEPARATED [ ]DIVORCED [ ]WIDOWED
USE OF ALCOHOL: [ ] NEVER [ ] NO LONGER USE [ ]HISTORY OF ALCOHOL ABUSE
[ ] CURRENT USE - TYPE __________________ [ ]RARE [ ]OCCASIONAL [ ]MODERATE [ ]DAILY

USE OF TOBACCO: [ ] NEVER [ ] QUIT – HOW LONG AGO? _________ [ ] SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: [ ] NEVER [ ] QUIT – HOW LONG AGO? _________ TYPE _______________________

[ ] CURRENT USE - TYPE _______________ [ ]RARE [ ]OCCASIONAL [ ]MODERATE [ ]DAILY

EMPLOYER: _______________________________________ OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? [ ]10% [ ]25% [ ]50% [ ]75% [ ]100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? [ ]CHILDREN–AGE(S) _______ [ ]PET(S)–WHAT KIND? ________
[ ]ELDERLY OR DISABLED FAMILY MEMBER [ ]OTHER ____
EXERCISE: [ ] NEVER [ ]RARE [ ] OCCASIONAL [ ]WEEKLY [ ]SEVERAL TIMES A WEEK [ ]DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: [ ] DIABETES: TYPE 1 OR TYPE 2 [ ]CANCER [ ]HEART DISEASE
[ ]HIGH BLOOD PRESSURE [ ]STROKE [ ] CORONARY ARTERY DISEASE [ ] THYROID DISEASE
[ ] RHEUMATOID ARTHRITIS
[ ]OTHER ____

YOUR MEDICAL HISTORY

ALLERGIES: [ ] MEDICATIONS ____
[ ] ANESTHESIA _________________________________ [ ] FOODS ____________________________________
[ ]TAPE [ ] LATEX [ ]SHELLFISH [ ] IODINE [ ]OTHER ________________________
[ ]NONE KNOWN

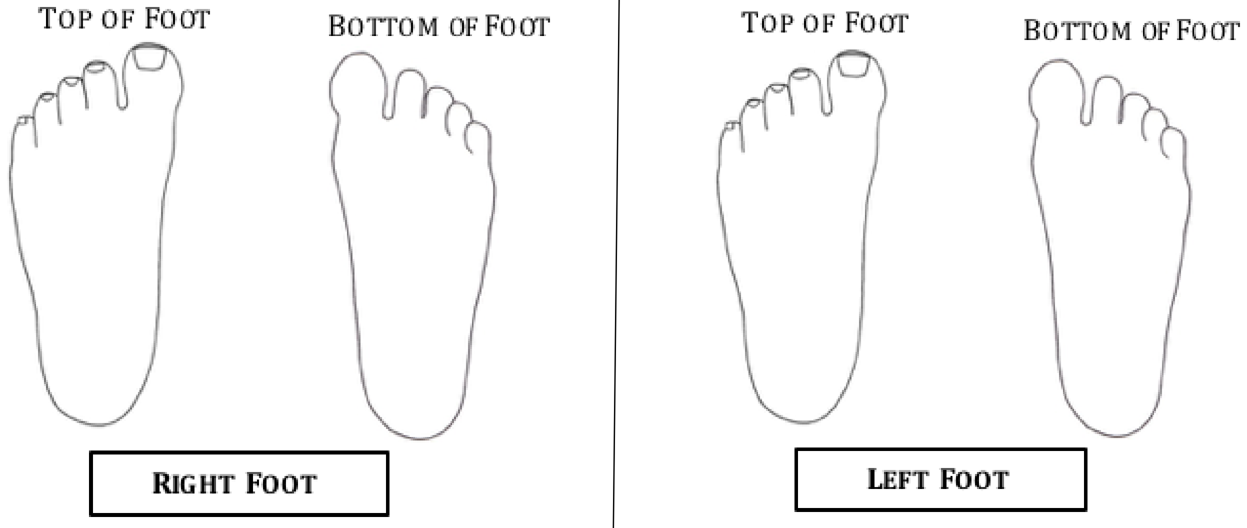
HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	☐	FIBROMYALGIA	☐	NEUROPATHY	☐
ANEMIA	☐	GOUT	☐	OPEN SORES	☐
ARTHRITIS	☐	HEART ATTACK	☐	PNEUMONIA☐	☐
ASTHMA	☐	HEART DISEASE/FAILURE	☐	POLIO	☐
BACK TROUBLE	☐	HEPATITIS	☐	RHEUMATIC FEVER	☐
BLADDER INFECTIONS	☐	HIV+/AIDS	☐	SICKLE CELL DISEASE	☐
ABNORMAL BLEEDING	☐	HIGH BLOOD PRESSURE	☐	SKIN DISORDER	☐
BLOOD CLOTS	☐	KIDNEY DISEASE	☐	SLEEP APNEA	☐
BLOOD TRANSFUSION	☐	LIVER DISEASE	☐	STOMACH ULCERS	☐
BRONCHITIS/EMPHYSEMA	☐	LOW BLOOD PRESSURE	☐	STROKE	☐
CANCER	☐	MIGRAINE HEADACHES	☐	THYROID DISEASE	☐
DIABETES: TYPE 1 OR TYPE 2	☐	MITRAL VALVE PROLAPSE	☐	TUBERCULOSIS	☐
OTHER CONDITIONS:					

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? __________ DAYS / WEEKS / MONTHS / YEARS (CIRCLE ONE)

DID YOUR PAIN OR PROBLEM: [ ] BEGIN ALL OF A SUDDEN [ ] GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? [ ]NO PAIN [ ] SHARP [ ]DULL [ ]ACHING [ ] BURNING
[ ]RADIATING [ ]ITCHING [ ] STABBING [ ]OTHER ____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: [ ]STAYED THE SAME [ ]BECOME WORSE [ ]IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? [ ]WALKING [ ] STANDING [ ] DAILY ACTIVITIES
[ ]RESTING [ ]DRESS SHOES [ ]HIGH HEELS [ ]FLAT SHOES [ ]ANY CLOSED TOE SHOE
[ ]RUNNING [ ]OTHER ____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ____
WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____
HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________________
WAS THIS PROBLEM CAUSED BY AN INJURY? [ ]YES (DESCRIBE) _____________________________________ [ ]NO
IF YES, WAS IT A WORK-RELATED INJURY? [ ]YES [ ]NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____ ____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN **SIGNATURE OF DOCTOR**

____ ____
SIGNATURE **DATE**

Dr. Elvira Callahan

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

I understand that I am financially responsible for all my charged not covered by my insurance company. Payment plans are available to me. My balance is to be paid in full within 90 days from the date of service. should this balance not be paid in full by this time, and no payment plan was established I understand my account will be forwarded to a collection agency along with a collection fee equal to 100% of my balance.

____ ____________________

Patient's Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature