NEW PATIENT REGISTRATION

DATE:_____/_____/_____

PATIENT INFORMATION

Patient Name:	**DOB:**
Marital Status: Single Married Divorced Widowed Other	**Primary Language:** English Other:
Race*: Native Am./or Alaskan Native Asian African Am./or Black Hispanic/or Latino Native Hawaiian/or Pacific Isl. White Withheld	
Ethnicity*: Non-Hispanic/Non-Latino Hispanic/or Latino Withheld	***Government Requirement**
SSN:	**Occupation:** / **Employer:**
Current address:	
Home#	**Cell#** / **Carrier** / **Work#**
Email:	**Referred by:**
Preferred Method of Communication: Phone -Home Phone -Cell Phone-Work Email	
Primary Care Physician:	**Phone:**
Emergency Contact/Auth. Med.Release:	**Phone:**
Contact/Release Relationship to patient: Spouse Parent Guardian Sibling Other:	
List any persons you explicitly prohibit from disclosure of information:	

INSURANCE INFORMATION

Insurance Co. Name:	
ID #:	**Group #:**
Relationship to Policy Holder: Self Spouse Parent Other	**If you circled SELF** move on to Current Condition
Policy Holder's Name:	**Phone#:**
Policy Holder's DOB:	**Policy Holder's Employer:**
Does the Policy Holder have a different address from the patient? No Yes	If yes, please add it below.
Policy Holder's Address:	

CURRENT CONDITION (PLEASE LIST IN ORDER OF SEVERAITY)

AREA OF INJURY/CONDITION	**WHEN DID YOUR SYMPTOMS BEGIN?**	
1.)	____/_____/_____	Gradual Chronic Just came on Sports Injury
Location: Left Right Bilateral		Slip/Fall Work Injury Auto Accident Other
Symptoms worse:	Morning Afternoon Evening Night Sleep With Activity Other:	
Unable to:	Sit Stand Walk Bend Lift Lie Other:	
Symptom frequency:	Constant Come & Go Other:	

Continue -→

2.)				____/_____/_____			Gradual Chronic Just came on Sports Injury	
Location: Left Right Bilateral							Slip/Fall Work Injury Auto Accident Other	
Symptoms worse:	Morning	Afternoon	Evening	Night	Sleep	With Activity	Other:	
Unable to:	Sit	Stand	Walk	Bend	Lift	Lie	Other:	
Symptom frequency:	Constant	Come & Go	Other:					
3.)				____/_____/_____			Gradual Chronic Just came on Sports Injury	
Location: Left Right Bilateral							Slip/Fall Work Injury Auto Accident Other	
Symptoms worse:	Morning	Afternoon	Evening	Night	Sleep	With Activity	Other:	
Unable to:	Sit	Stand	Walk	Bend	Lift	Lie	Other:	
Symptom frequency:	Constant	Come & Go	Other:					
4.)				____/_____/_____			Gradual Chronic Just came on Sports Injury	
Location: Left Right Bilateral							Slip/Fall Work Injury Auto Accident Other	
Symptoms worse:	Morning	Afternoon	Evening	Night	Sleep	With Activity	Other:	
Unable to:	Sit	Stand	Walk	Bend	Lift	Lie	Other:	
Symptom frequency:	Constant	Come & Go	Other:					

QUESTIONS REGARDING YOUR PAIN						
Does your pain interfere with:	Normal Daily Activities	Driving	Exercising	Sleep	Work	Other:
Have you treated with any other health care provider for these complaints?	Yes	No	If yes, please list treatments & outcomes:			

CURRENT PATIENT HISTORY									
1.	**Current tobacco use**	Never	Lives with smoker	Former : ____ years quit	Light: ____ years smoked	Every day: ____ years smoked			
		Heavy: ____ years smoked	**Type of tobacco use**	Cigarette	Cigar	Pipe	Chew	Dip	
2.	**Do you have dietary restrictions?**	Yes	No	If yes:					
3.	**How frequently do you exercise?**	Never	Avoids due to pain	Limited	Infrequent	Occasional	Regular	Frequent	
4.	**Current alcohol use**	Never	Rarely	Socially	Moderately	Frequently	Heavily	Recovering Alcoholic : _____ # of years	
5.	**List any over-the-counter drugs, vitamins, supplements you are currently taking:**								
6.	**List all prescribed medications and dosage that you are currently taking:**								
7.	**Do you have any allergies, medical or non-medical:**	Yes	No	If yes:					
8.	**Do you have a pace maker or any other device that could impede treatment?**	Yes	No	If yes:					

PAST PATIENT HISTORY						
1.	**List any serious accidents, illnesses, surgeries, or fractures along with approx. date:**					
	____/_____/_____ : _____ ____/_____/_____ : _____					
	____/_____/_____ : _____ ____/_____/_____ : _____					
2.	**List any illnesses/conditions that you have been diagnosed with:**					
3.	**Circle any childhood illnesses/diseases you've had:**	Mumps	Measles	Chicken Pox	Polio	Other:

IMMEDIATE FAMILY HEALTH HISTORY			
List any serious health problems that affect any of your immediate family members			
1.	**Mother:**	2.	**Father:**
3.	**Sibling(s):**		
3.	**Other Relative(s):**		

(Optional) Add additional information pertaining to your condition

By signing this form I am authorizing that to the best of my knowledge I have provided Dr. Malcolm Conway with an accurate and complete representation of my medical history and current conditions.	
Signature of patient (or guardian):	Date: