New Patient Form

Apex Posture and Sport
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Phone: 602-661-7752
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Name: _____ How did you hear about us?:_____
Address: _____ City: _____ State: _____ ZIP: _____
Cell Phone: _____ Home Phone: _____ SSN: _____
E-mail: _____ DOB: _____ Age: _____ Gender: _____
Emergency Contact:_____ Emergency Contact Phone #: _____
Marital Status: _____ Children: Yes / No How Many:_____
Employment Status: Yes / No Occupation: _____ Employer: _____

Do you have Insurance: Yes / No Insurance Name: _____
Primary Insured: Yes / No Primary Insured Name: _____
Relationship to you: _____ Primary Insured DOB:_____

Family Physician: _____ Phone: _____

Current Medications

RX Medications/OTC	Dosage	Frequency	How is it Consumed?
1)			Orally Topically Injected
2)			Orally Topically Injected
3)			Orally Topically Injected
4)			Orally Topically Injected
5)			Orally Topically Injected

List any known allergies if you have had to any medications, foods, or environmental factors:
1)_____ 2) _____ 3) _____ 4) _____

Family History: Please check any condition you OR your family have or have had in the past **(P = Patient, F = Family)**

○ Alcoholism---------- P / F	○ High Blood Pressure ------- P / F	○ Stroke ---------- P / F
○ Anemia ---------- P / F	○ Kidney Disease ---------- P / F	○ Suicide Attempt ---------- P / F
○ Asthma ---------- P / F	○ Liver Disease ---------- P / F	○ Thyroid Disease---------- P / F
○ Cancer/ Tumor ---------- P / F	○ Hepatitis ---------- P / F	○ Heart Disease---------- P / F
○ Diabetes---------- P / F	○ Lung Disease ---------- P / F	○ Ulcers ---------- P / F
○ Drug Abuse ---------- P / F	○ Rheumatoid Arthritis------ P / F	○ HIV or Immune Disease --- P / F
○ Depression---------- P / F	○ Osteoarthritis ---------- P / F	○ High Cholesterol ---------- P / F
○ Epilepsy/Seizures---------- P / F	○ Osteoporosis ---------- P / F	○ Other: P / F

Past Health History: Please mark any condition you have now or had in the past

General
- ○ Weight Loss
- ○ Fatigue
- ○ Fever

Musculoskeletal
- ○ Joint Pain
- ○ Stiffness
- ○ Swollen Joints
- ○ Muscle Pain

Psychiatric
- ○ Anxiety
- ○ Depression

Gastric/Urology
- ○ Erectile Dysf.
- ○ Leaky Bladder
- ○ Blood in Urine
- ○ Freq. Urination
- ○ Pain Urinating

EENT
- ○ Difficult Hearing
- ○ Ear Ringing
- ○ Vertigo
- ○ Sinus Trouble
- ○ Sore Throat
- ○ Glasses
- ○ Eye Pain
- ○ Double Vision

Hematology
- ○ Easy Brusing
- ○ Easy Bleeding

Endocrine
- ○ Hair Loss
- ○ Weight problem
- ○ Thyroid

Respiratory
- ○ Coughing
- ○ Asthma
- ○ COPD
- ○ Bronchitis

Cardiovascular
- ○ Heart Murmur
- ○ Chest Pain
- ○ Palpitations
- ○ Short Breath
- ○ Fainting
- ○ Swollen Ankles

Females ONLY
- ○ Abnormal mam.
- ○ Abnormal Preg.
- ○ Pregnant? Y / N

Skin
- ○ Rash
- ○ Itching
- ○ Lesions

Gastrointestinal
- ○ Heartburn
- ○ Nausea
- ○ Constipation
- ○ Diarrhea
- ○ Abdominal Pain

Neurological
- ○ Strength Loss
- ○ Numbness
- ○ Tremors
- ○ Memory Loss
- ○ Headaches
- ○ Migraines

New Patient Form

1st Chief Complaint:_____ When did it start?_____ Gradual / Sudden

Circle the CURRENT level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the WORST level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the percentage of the day you experience the pain
10 20 30 40 50 60 70 80 90 100

2st Chief Complaint:_____ When did it start?_____ Gradual / Sudden

Circle the CURRENT level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the WORST level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the percentage of the day you experience the pain
10 20 30 40 50 60 70 80 90 100

3st Chief Complaint:_____ When did it start?_____ Gradual / Sudden

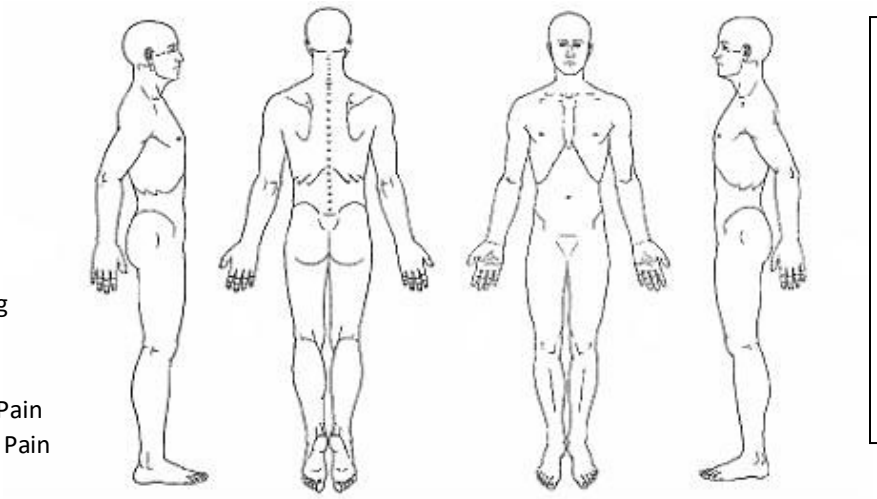
Circle the CURRENT level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the WORST level of your pain
1 2 3 4 5 6 7 8 9 10

Circle the percentage of the day you experience the pain
10 20 30 40 50 60 70 80 90 100

Using the Letters Below, please show WHERE you are experiencing ALL your complaints:

A = Ache
B = Burning
C = Cramping
D = Dull Pain
F = Stiffness
N = Numbness
T = Tingling
TH = Throbbing
S = Soreness
X = Sharp
SP = Shooting Pain
RP = Radiating Pain



DOCTORS NOTES:

Have you ever had any tests or imaging for your present condition? _____
Do you drink alcohol? Yes / No If yes, how many drinks per week? _____
Do you smoke or use tobacco products of any kind? Yes / No If yes, how often? _____
When was your last physical examination? _____ Do you have a pacemaker? Yes / No
Any previous surgeries? Yes / No (If yes, please list below with dates)

_____

_____

Patient Name: _____ Patient Signature: _____ Date:_____

DOCTORS NOTES:

_____

_____

_____

_____