Wilmington Clinic

PATIENT INFORMATION Date:_____

Last Name:_____First Name:_____

Primary Address/Apt#:_____

City:_____State:_____Zip Code:_____

Primary Phone#:_____Cell Phone #:_____

Opt in for text appointment reminders? Y____N____ If yes, cell provider:_____

Email:_____

Opt in for email appointment reminders? Y____N____ Occupation:_____

Date of Birth:_____Age:_____Sex: M____F____

Marital Status:_____Emergency Contact:_____

Insurance Provider:_____Doctor To Be Seen:_____

Referred By:_____

PATIENT HEALTH HISTORY

Describe the reason for today's visit:_____
_____

_____

Is this a prior issue? Y__N__ Have you seen another doctor for this condition? Y__N__
If yes, when?_____

Is your visit due to an: Auto Accident__Work Injury__Other__Date of occurrence:_____

Current Medical Conditions (ie: High Blood Pressure, Diabetes, Cancer, etc):

_____ _____

_____ _____

_____ _____

List Prior Surgeries:

_____ _____

_____ _____

Current Medications and Dosage:

_____ _____

_____ _____

_____ _____

_____ _____

List Any Known Allergies:

_____ _____

_____ _____

Are you a smoker? Y____N____ If yes, how often? Daily__Occasionally__Rarely__

Area of Complaints: (check all that apply)

__Neck __Neck/Upper Back __Neck pain radiating down arm__Upper Back Pain

__Headaches __Mid Back Pain __Low Back Pain __Low Back pain radiating down leg

__Buttocks Pain __Shoulder Pain __Arm Pain __Elbow Pain

__Forearm Pain __Wrist Pain__Hand Pain __Hip Pain

__Leg Pain __Thigh Pain __Knee Pain __Calf Pain

__Ankle Pain __Foot Pain __Jaw Pain __Nasal related issues

__Routine Spinal Care

Pain Level: 1-10 (1-least, 10-highest):_____

Nature of Pain: (check all that apply)

__Dull Ache __Sharp __Stiff __Sore __Tight __Cracking __Numbness __Pins/needles

__Headache __Radiating __Shooting __Stabbing __Throbbing __ Burning __Dizziness

__Congestion __Nasal Drainage __Nasal Stuffiness

Pain Intensity: Mild__Moderate__Severe__

Frequency of Pain: Constantly__ Frequently__ Occasionally__

Worse in the morning___, afternoon___, evening___

What Makes Pain Better: Nothing__, ice/heat__, sleep/rest__, medicine__, stretching__.

Family History: (check all that apply)

__Heart Disease __Thyroid __Diabetes __Arthritis __Cholesterol

__High Blood Pressure __Psychiatric __Stroke __Cancer

Explain yes answers:_____

_____