

NEW PATIENT REGISTRATION

PATIENT INFORMATION				
Name:		Medical Record #:		
Birthdate:	Provider: Dr. Abbasi Dr. Kim			
Current Address:		CITY	STATE	ZIPCODE
Is this address a skilled nursing facility, assisted living, or group home?: <input type="checkbox"/> YES <input type="checkbox"/> NO				
Preferred Method of Contact (circle one): HOME CELL WORK				
Home Phone:		Cell Phone:		Work Phone:
Email:				
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Other: _____		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Emergency Contact:		Phone Number:		
PRIMARY CARE PROVIDER: Clinic: _____ Provider: _____				
How did you hear about us? <input type="checkbox"/> Provider Referral : _____ <input type="checkbox"/> Billboard <input type="checkbox"/> TV/Radio <input type="checkbox"/> Internet (Website, Google, etc.) <input type="checkbox"/> Other: _____				
INSURANCE INFORMATION				
Copies of Insurance Card(s) and Photo ID will be obtained at check in *COPAYS ARE DUE AT THE TIME OF CHECK IN*				
Primary Insurance:		ID:		
Group #:		Effective Date:		
Secondary Insurance:		ID:		
Group #:		Effective Date:		
Is this condition related to auto, liability or a workman's compensation case? <input type="checkbox"/> YES <input type="checkbox"/> NO **If yes, please complete the next section**				
AUTO/WORKERS COMP CLAIM INFORMATION				
Date of Injury:		Injured Body Part:		
Insurance Company:		Claim Number:		
Adjuster Name:		Adjuster Phone Number:		Adjuster Fax Number:
Do you have a Qualified Rehabilitation Consultant? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, QRC Name: _____				
MEDICAL HISTORY				
Identify and of the following Diagnosis(es) that are relevant to you				
<u>GENERAL</u> Cancer: _____ Arthritis Lupus Thyroid problem Diabetes Osteoporosis Fibromyalgia Carpal Tunnel	<u>LUNG</u> Asthma Pneumonia Emphysema Tuberculosis	<u>PSYCHOLOGICAL</u> Anxiety Bipolar Disorder Depression Schizophrenia	<u>NEUROLOGICAL</u> Stroke Brain tumor Headaches Back injury Neck injury Head injury Seizure Epilepsy Parkinson Disease	<u>BLOOD</u> Anemia Blood Clots Previous Transfusion Bleeding problems



<p style="text-align: center;"><u>GI</u></p> <p>Hepatitis GERD Heartburn Liver disease Colitis Ulcers</p>	<p style="text-align: center;"><u>CARDIOVASCULAR</u></p> <p>Heart Attack Hypertension High Cholesterol Atrial Fibrillation Pacemaker Carotid Disease Coronary Artery Disease</p>	<p style="text-align: center;"><u>GU</u></p> <p>Kidney Problem Kidney Stones Urinary Tract Infection Bladder Problem Prostate Problem</p>	<p>Multiple Sclerosis Other:</p>
Do you currently smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, how many packs per day? How many years?	
Are you a former smoker? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, how many years smoke free?	
Do you currently use smoke-less tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO		Former user? Years tobacco free?	
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, how many drinks per week?	
IMAGING			
Have you had any imaging (CT/MRI/Xray) completed related to your visit? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, what area of the body was imaged? _____ Where was the imaging completed? _____			
IF IMAGING AVAILABLE, IT IS NEEDED AT THE TIME OF VISIT If we do not have imaging, we may not be able to complete the visit			
MEDICATIONS			
List any medications you are currently taking			
Medication	Dose	Frequency	
ALLERGIES			
List any allergies to food, medications, latex, etc.			
<input type="checkbox"/> NKA			
Allergy	Type of Reaction	Severity (mild, moderate, severe)	
PAST SURGICAL HISTORY			
Have you ever had surgery before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list history below			
Type of Surgery	Year Completed		
REVIEW OF SYSTEMS			
What are your main symptoms, and how long have you had these symptoms? _____ _____ _____			
Bowel or Bladder Incontinence? <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____			
Please rate your symptoms from 0 (no symptoms) to 10 (very severe):			
	PAIN		
	NUMBNESS		
	WEAKNESS		