Patient Basic Information

***NOTE: Please Fill This Out as Thoroughly and NEATLY as Possible, as This Information Is Needed to Properly Process Your Insurance Claim or to Complete Your Computer Data File**

Today's Date:	**Date of Injury/Onset:**	**Patient No.** (do NOT fill out)
Last Name:	**First Name:**	**Middle Initial:**
Address:	**City, State, Zip**	
Home Phone:	**Cell Phone:**	**Work Phone:**
Email:		**Last 4 digits of SS#**
Date of Birth:	**Age:**	**Date of First treatment**

Notification Preference:
Appointment Reminders

Please pick one:
- ☐ Text Msg. (90 min prior to appt)
- ☐ Call Cell or ☐ Call Home (24 hours prior to appt)
- ☐ Email (48 hours prior to appt)

Occupation (describe briefly what you do):

Employer Name and Address:

Work Activities Include:
☐Sitting ☐Standing ☐ Light Labor ☐ Heavy Labor ☐ Other_____

How did you hear about us?
☐ Family/Friend/Co-Worker _____ ☐ Internet (☐ Website ☐ Google)
☐ Yellowpages ☐ Provider List ☐ Doctor ☐ Live/Work Nearby ☐ Sign ☐ Other _____

☐ Part-Time ☐ Full-Time Student **Where:**	**Marital Status:** ☐Single ☐ Married ☐ Divorced ☐ Widowed
Spouse's/Significant Other's (SO) name:	**Spouse's/SO Occupation:**

Emergency Contact Information:

Name: _____ **Relationship:** _____

Hm Phone: _____ **Cell Phone:** _____ **Wk Phone:** _____

Days of Work Missed related to this Injury/Condition: _____ days	**Date returned to work?** _____ ☐ Not yet back to work	**Returned at:** ☐ Light Duty ☐ Modified Duty ☐ Regular Duty

Treatment History: Fill in any treatment for this condition/injury) prior to your 1st visit to this office.

1. Dr. _____ First visit date: ____/____/____ Specialty:_____

X-rays done? Yes☐ No☐ Body parts X-rayed?_____

The X-rays revealed: _____

Types of treatments received:_____

Was lab work done? Yes☐ No☐ What lab work?_____

How many treatments received? ____ Currently treating? Yes ☐ No☐ Last visit date: ____/____/____

Past Medications from this incident:_____

Follow-up instructions: _____

2. Dr. _____ First visit date: ____/____/____ Specialty:_____

X-rays done? Yes☐ No☐ Body parts X-rayed?_____

The X-rays revealed: _____

Types of treatments received:_____

Was lab work done? Yes☐ No☐ What lab work?_____

How many treatments received? ____ Currently treating? Yes ☐ No☐ Last visit date: ____/____/____

Past Medications from this incident:_____

Follow-up instructions: _____

3. Dr. _____ First visit date: ____/____/____ Specialty:_____

X-rays done? Yes☐ No☐ Body parts X-rayed?_____

The X-rays revealed: _____

Types of treatments received:_____

Was lab work done? Yes☐ No☐ What lab work?_____

How many treatments received? ____ Currently treating? Yes ☐ No☐ Last visit date: ____/____/____

Past Medications from this incident:_____

Follow-up instructions: _____

Dr Pearce Wellness Care
Review of Systems

Patient Name:_____ Today's Date:_____

Please check the signs and/or symptoms related to the following body systems you have now or have experienced in the past:.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaunice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy/ Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC/LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC/ IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

INSURANCE INFORMATION

Type of Insurance:

☐ Health Insurance ☐ Your Auto Insurance (PIP, UM, UM) ☐ 3rd Party Responsible

My Health Insurance Company _____Insured ID Number_____

Claim Address: _____ City_____ State___ Zip_____

Phone ( )_____ FAX ( )_____ Claim No. _____

My Auto Insurance Company _____ Adjuster's Name _____

Claim Address: _____ City_____ State___ Zip_____

Phone ( )_____ FAX ( )_____ Claim No. _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth_____

3RD PARTY'S Insurance Company _____ Adjuster's Name _____

Claim Address: _____ City_____ State___ Zip_____

Phone ( )_____ FAX ( )_____ Claim No._____