# KAISER FAMILY MEDICAL MANAGEMENT

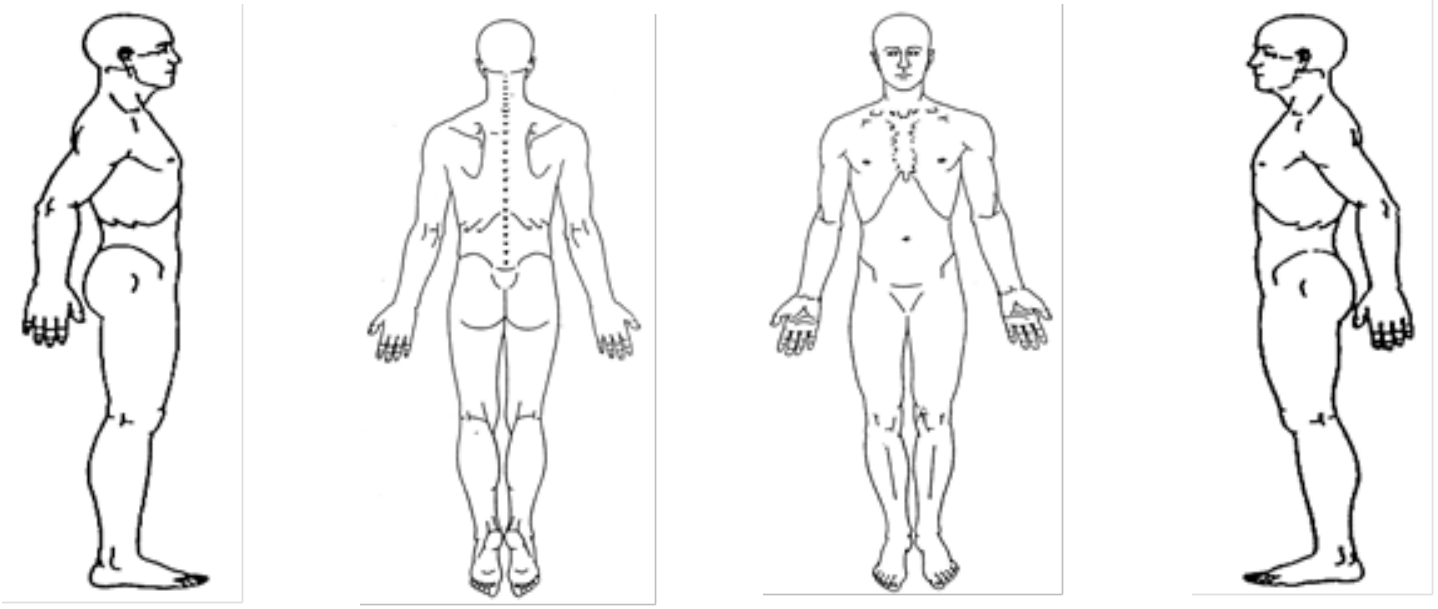
## NEW PATIENT INTAKE

Name: _____
Address: _____
City / State / Zip: _____
Home # _____ Work # _____
Cell # _____ Email _____
Sex: M / F Date of Birth: _____ Age: _____
Social Security # _____
Marital Status: S / M / D / W / SEP
Emergency Contact: _____
Emergency Contact Phone # _____
How did you hear about us? _____
May we email you a monthly newsletter? Yes / No

Date: _____
Employer: _____
Occupation: _____
Address: _____
City / State / Zip: _____
Telephone: _____
Insurance Company: _____
Insurance Phone # _____
Policy Holder: _____
Policy Holder SS # _____
Who referred you? _____
Email address: _____

## PLEASE CIRCLE & MARK ALL COMPLAINT AREAS

| | | | | | |
|---|---|---|---|---|---|
| Head / Face | Thigh | Shoulder blade | Chest | Skin | Blood |
| Neck | Knee | Arm | Abdomen | Ears | Heart |
| Mid-back | Ankle | Elbow | Groin | Eyes | Gastro-intestinal |
| Lower back | Foot / Toes | Wrist | Breast | Nose | Genital-urinary |
| Hip / Glutes | Shoulder | Hand / Fingers | Lung | Mouth / Throat | Ob / Gyn |
| Poor Nutrition | Body Fat | Lack of Energy | Hormones | | |



## PLEASE CIRCLE ALL AREAS OF INTEREST

| | | | |
|---|---|---|---|
| Medications | Physical therapy | Spinal Decompression | Nutritional support |
| Pain management | Chiropractic care | Acupuncture | Anti-aging |
| Injections | Rehabilitative therapy | Braces / Supports | Weight loss |
| Advanced pain management | Post-operative therapy | Laser therapy | Neuro-transmitters |
| Laboratory services | Cryotherapy | Neuropathy therapy | Personal training program |

## PAST MEDICAL HISTORY

**Please circle all current & prior history of conditions**

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcoholism | Anemia | Appendicitis | Asthma | Bronchitis | Cancer | Chicken pox |
| Cold sores | Diabetes | Eczema | Edema | Emphysema | Epilepsy | Thyroid disease |
| Gout | Heart burn | Heart disease | Hepatitis | Herpes | HIV / AIDS | High Cholesterol |
| Influenza | Malaria | Measles | Polio | Miscarriage | Mumps | Panic Disorder |
| Tingling | Pace maker | Osteoporosis | Pneumonia | Insomnia | Migraines | Multiple Sclerosis |
| Ulcers | Tuberculosis | Goiter | Stroke | ADHD | ADD | Rheumatic fever |
| Depression | Anxiety | Numbness | Hormones | Weight Control | EBV | Hypertension |

Other:_____

**Please list any prior traumas / symptoms / accidents within the past 2 years.**

Date: _____ Description: _____
Date: _____ Description: _____
Date: _____ Description: _____
Other:_____

**Please list all current medications:**

_____ _____
_____ _____
_____ _____

**Please list all past surgeries.**

Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____

**Please circle all that apply.**

Exercise level: None / Light / Moderate / Heavy / Regular / Infrequent _____
Alcohol use: None / Rarely / Socially / Regularly / Usage/Type: Qty / day: _____
Tobacco use: None / Rarely / Socially / Regulary / Usage/Type: Qty / day: _____

Who was your last general physician? _____ Who was your last Chiropractor? _____

## MVA / PERSONAL INJURY / WORK RELATED INJURY QUESTIONAIRRE

Date of accident: _____ Time of accident: _____ Location: _____
Accident description: _____
_____
_____

MVA Questionairre:
Did the vehicle go off of the road? Y / N How long were you in the car before getting out? _____ Min / hour(s).
What parts of your body struck the inside of the care if any? _____ Were you awake or asleep? _____
Which of the following did you have on? Seatbelt / Shoulder harness / Both / Neither. What was the posted speed? _____
What was your speed at the point of impact? _____ Was a report or citation issued? Y / N By who? _____
Traffic conditions: Congested / Heavy / Good / Light / Normal / Rush hour. What area of your car was hit?_____
What is the year, make and model of you car? _____ Who is the owner of the car? _____
Were you the driver or passenger? _____ How many other people were in the car? _____
Weather conditions? Foggy / Rainy / Normal / Poor visibility / Snow / Windy / Icey / Other: _____
Where did you go after the accident? Home / Hospital / ER / Minor emergency center / Other: _____
_____
_____

By my signature, I acknowledge that all of the information provided is true and correct as to the best of my knowledge. I also, the patient, give consent and authorization to be examined and diagnosed by the doctors of the Southtexas Spine & Joint Institute through examinations and / or diagnostic tests. I also, the patient, give consent and authorization to be treated conservatively until exam and diagnostic tests are reviewed.

_____ _____
**Patient Signature** **Date**