NEW PATIENT INFORMATION FORM

Name:_____ Date:_____ Time:_____

Home Phone: _____ Cell Phone: _____ Email: _____

Height:_____ Weight:_____ DOB:_____ Shoe Size____

Marital Status: ___ Married ___Divorced _____ Separated _____ Widowed _____Single

Reason for today's visit:_____

_____

If previously seen by Dr. Prisk please provide date and reason for last visit _____

_____

Date of injury or onset of complaints:_____

Is this injury work related? ☐ Yes ☐ No Employer:_____

Currently Working? ☐ Yes ☐ No Last day worked:_____

Auto Accident? ☐ Yes ☐ No

Primary Care Physician and Phone Number:_____

Referring Physician (If not the same as Primary Care Physician):_____

Preferred Pharmacy _____ Address: _____

Patient Medical History	YES	NO	Please detail all "YES" answers
Eye, Ear, Nose Throat			
Heart Disease			
Lung Disease			
Kidney/Liver Disease			
Stomach/Intestinal Disease			
Arthritis/Bone/Joint Muscle Disease			
Diabetes			
Epilepsy			
Cancer			
Vascular Disease			
Thyroid Disease			
High Blood Pressure			
Bleeding/Clotting Disorders			
Psychiatric Problems			
Other:			

Surgeries (type and date):_____

_____

Hospitalizations (other than for surgeries above):_____

_____

Current Medications (list all medications including prescription, over the counter, vitamins & supplements):_____

_____

Allergies (or bad reactions) to medications:_____

_____

Social History:

Do you use Tobacco? ☐ Yes ☐ No Amount/Duration:_____

Do you use Alcohol? ☐ Yes ☐ No Amount/Duration:_____

Do you use Recreational Drugs? ☐ Yes ☐ No If yes, what substance?_____

Amount/Duration:_____

Occupation (w/brief job description):_____
Employer: _____
Highest Level of Education:_____
Recreational Activities:_____
Family History:_____
_____

	Please indicate if you are or have experienced the following:	**Explain**
	Headache/Dizziness/Visual Disturbances	
	Throat trouble, ringing in ears, runny nose	
	Chest pain/palpitations/irregular heart beat	
	Shortness of Breath/Cough	
	Heartburn/Nausea/Vomiting	
	Burning/Frequency of Urination or Vaginal Discharge	
	Muscle/Bone/Joint/Pain or Stiffness	
	Changes in skin color/texture/moles or rashes	
	Swelling, discoloration/temperature change of extremity	
	Loss of sensation	
	Lower back pain	
	Fever/Chills/Sweats/Fatigue	
	Easy bruising or bleeding disorder	
	Weight loss or gain	
	Excessive worry/anxiety/depression or trouble sleeping	
	Excessive thirst or hunger	
	Dietary restriction	
	Glasses or Contacts	
	Dentures or Partials	

Patient Signature:_____ Date:_____

Physician Signature of Initial Review:_____ Date:_____

Periodic updates:
Date:_____ Changes made? Yes_ No___ Physician/Staff signature_____
_____
_____

Periodic updates:
Date:_____ Changes made? Yes_ No___ Physician/Staff signature_____
_____
_____

Periodic updates:
Date:_____ Changes made? Yes_ No___ Physician/Staff signature_____
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