MEDICATIONS

Name of Medication	Doctor's Name	Reason for Medication	Side Effects

PLEASE LIST ALL
DOCTORS, CLINICS AND HOSPITALS

Name of YOUR CURRENT/PRIMARY CARE Doctor:______________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

Name of Doctor, Clinic or Hospital: _______________________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

Name of Doctor, Clinic or Hospital: _______________________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

Name of Doctor, Clinic or Hospital: _______________________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

Name of Doctor, Clinic or Hospital: _______________________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

Name of Doctor, Clinic or Hospital: _______________________________________
Address: ____
City _______________________ State _________________ Zip Code __________
Phone No:_______________________ Fax No.: ___________________________
Reason for treatment:____
Date of Last Visit: ________ Date of Next Visit:_________Date of First Visit:________

IV. WORK EXPERIENCE

ARE YOU PRESENTLY WORKING? YES___ NO___ EMPLOYER_____

DATE LAST WORKED: _____

Where have you worked in the past 15 Years?

1._____ FROM _____ TO _____
2._____ FROM _____ TO _____
3._____ FROM _____ TO _____
4._____ FROM _____ TO _____
5._____ FROM _____ TO _____
6._____ FROM _____ TO _____

V. MEDICAL PROBLEMS: Please list all

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Do you need a cane, back brace, or other assistive device? YES __ NO ___ If **YES** what assistive device(s) do you use:_____

Does someone help you with r daily activities? YES __ NO __ If **YES** Describe _____

_____

Who helps you with these activities? _____

What activities can you do for yourself? What do you do during the day? Explain _____

_____

_____

Do you Drive? YES __ NO ___ If **NO** when did you stop?_____

EMOTIONAL CONDITION Have you felt any of the following? Please mark all that apply

_____ Depression/Anxiety
_____ Hopeless or Helpless
_____ Easily aggravated/Irritable
_____ Thought about suicide
_____ Keep to yourself/Withdrawn
_____ Guilty or Worthless
_____ Sleep Problems
_____ Difficulty concentrating
_____ Easily distracted
_____ Memory Problems

Have you ever been seen by a Psychiatrist? YES __ NO __

Have you ever been hospitalized for mental problems? YES __ NO __

Do you Smoke ? YES __ NO __ Use Alcohol? YES__ NO ___ Use Drugs? YES __ NO __

Treatment for Alcohol or Drug abuse? YES __ NO __ If YES Date(s)_____

Have you ever been convicted of a Felony? YES___ NO ___ If YES Explain When, Where & Why _____

_____

CONFIDENTIAL INFORMATION

Date _____

Name _____ **Social Security Number**_____

Address_____ Tel. No. _____

_____ Birth date _____ Age _____

Email address:_____ Gender: _____

Alternate Contact Person:_____ **Tel. No:** _____

Alternate Contact Person Address:_____

What is your Mother's Maiden Name: _____

What City and State were you born in:_____

How did you find out about our office:_____

I. FAMILY

Married ____ Single ____ Divorced ____ Separated ____ Widowed ____

Spouse's Name _____ His/Her employment_____

Spouse's Phone _____ No. of Children _____ Ages _____

With whom do you live:_____

Date Applied for Social Security _____ **Ever filed before** _____ **Date filed** _____

II. INCOME

DO YOU HAVE ANY INCOME:_____

Do you **NOW** receive Unemployment Benefits? YES___ NO ___ If **YES** how much $_____

Do you **NOW** receive Worker's Compensation? YES ___ NO ___ If **YES** how much $_____

Have you **ever received** either of these benefits? YES ___ NO ___ If **YES** When?_____

Do you receive any of the following benefits? If Yes please list amount of benefits received

VA Benefits? YES ___ NO ___ Amount $_____ Disability percentage _____

Retirement/Pension? YES __ NO __ $ _____ Long Term Disability? YES __ NO __$ _____

Food Stamps? YES ___ NO ___ $_____ Child Support? YES ___ NO ___ $_____

DO YOU OWE/PAY CHILD SUPPORT? YES___ NO___ amount $_____

III. EDUCATION

Last grade completed _____ What year? _____

Education after High School _____

Do you have problems - Reading? YES __ NO __ Writing? YES __ NO __

Performing simple math (Add & Subtract) YES __ NO __

If **YES** to any of the above questions Please explain your problems _____

_____

_____