- Chandler - 1949 W. Ray Road #23, Chandler, AZ 85224 Ph: (480) 917-1720
- Mesa - 5233 E. Southern Ave, #104, Mesa, AZ 85206 Ph: (480) 830-2882
- Gilbert – 754 S. Val Vista Drive #105, Gilbert, AZ 85296 Ph: (480) 497-2900
- Phoenix – 2824 E. Indian School Rd. #5, Phoenix, AZ 85016 Ph: (602) 840-0056
- Tempe – 1855 E. Guadalupe Road #112, Tempe, AZ 85283 Ph: (480) 839-8552
- Queen Creek - 21323 S. Ellsworth Loop Rd #101, Queen Creek, AZ 85142 Ph: (480) 307-8440
- Ocotillo – 2815 E. Ocotillo Rd. #4, Chandler, AZ 85249 Ph: (480) 781-2964
- Desert Ridge- 21001 N. Tatum Blvd Suite 78-1640, Phoenix, AZ 85050 Ph: (480)-306-7832

Name_____**Nickname**_____**How did you hear about us** _____

Address_____**City**_____**State**_____**Zip**_____

Cell Phone_____**Home Phone** _____**SSN**_____

Home Email_____ **Date of Birth**_____ **Age**_____**Gender**❑Male❑Female❑Unspecified

Emergency Contact:_____**Contact Phone #**_____

Marital Status❑Single❑Married❑Other **Children** ❑ YES ❑NO How Many_____

Employment Status ❑Employed ❑FT Student❑PT Student❑Other❑Retired❑Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Do you have insurance? ❑Yes ❑No **Insurance Name:**_____

Primary insured?❑Yes ❑No **If no, primary insured name and relationship to self:** _____Their DOB_____

Family Physician _____ **Phone** _____

Current medications, COMPLETE FULLY:

RX Medication/Over The Counter	Dosage	Frequency	Circle how taken
1)			**Orally Topically Injectable**
2)			**Orally Topically Injectable**
3)			**Orally Topically Injectable**
4)			**Orally Topically Injectable**
5)			**Orally Topically Injectable**

List any known allergies you have had to any medications, foods or environment:

1) _____ **3)** _____

2) _____ **4)** _____

Do you suffered from seasonal allergies? ❑ Yes ❑ No If Yes, have you had allergy testing before? ❑ Yes ❑ No

Do you suffer from food sensitivity? ❑ Yes ❑ No If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. Please state (P) for Patient or (F) for family**

❑ Alcoholism **(P or F)** ❑ High Blood Pressure **(P or F)** ❑ Stroke **(P or F)**
❑ Anemia **(P or F)** ❑ Kidney Disease **(P or F)** ❑ Suicide Attempt **(P or F)** ❑ Asthma
(P or F) ❑ Liver Disease **(P or F)** ❑ Thyroid Disease **(P or F)** ❑ Cancer/Tumor **(P or F)**
❑ Hepatitis **(P or F)** ❑Heart Disease **(P or F)** ❑ Diabetes **(P or F)** ❑ Lung
Disease **(P or F)** ❑ Ulcers **(P or F)** ❑ Drug Abuse **(P or F)** ❑Rheumatic Arthritis
(P or F) ❑HIV or Other Immune Disease **(P or F)** ❑ Depression **(P or F)** ❑ Osteoarthritis
(P or F) ❑ High Cholesterol **(P or F)** ❑ Epilepsy/Seizures**(P or F)** ❑ Osteoporosis **(P or F)**
❑ Other _____

General	**GU**	**Hematology**	**Cardiovascular**	**GI**	**Skin**
❑Weight Loss	❑Erectile Dysfunction	❑Easy Bruising	❑Heart Murmur	❑Heartburn	❑Rash
❑Fatigue	❑Leaky Bladder	❑Easy Bleeding	❑Chest Pain	❑Nausea	❑Itching
❑Fever	❑Blood in Urine	**Endocrine**	❑Palpitations	❑Constipation	❑Lesions
MSK	❑Frequent Urination	❑Hair Loss	❑Short of Breath	❑Diarrhea	**Neurological**
❑Joint Pain	❑Painful urination	❑Weight Gain	❑Fainting	❑Abdominal Pain	❑Strength Loss
❑Stiffness	**ENT**	**Respiratory**	❑Swollen Ankles	**Eyes**	❑Numbness
❑Muscle Pain	❑Difficult Hearing	❑Coughing	**Females Only**	❑Glasses	❑Tremors
❑Swollen Joints	❑Ear Ringing	❑Asthma	❑Abnormal Mammo	❑Eye Pain	❑Memory Loss

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Psychiatric	❑Vertigo	❑Difficult Breathing	❑Abnormal Pap	❑Double Vision	❑Headaches
❑Anxiety	❑Sinus Trouble		Pregnant Y N		Frequency_____
❑Depression	❑Chronic Sore Throat				

Patient Signature: _____ Date: _____ Dr Initials _____

RV 08/2017

1st Chief Complaint: _____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint :_____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

A: Ache

B: Burning

C: Cramping

D: Dull Pain

F: Stiffness

N: Numbness

R: Throbbing

S: Soreness

T: Tingling

X: Sharp Pain

SP: Shooting Pain

RP: Radiating Pain

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Have you ever had tests for your present condition? ❑MRI ❑X-ray ❑ CT ❑Other

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Any Surgeries? ❑ Yes ❑No If yes, list:_____

_____

___