

- o Chandler - 1949 W. Ray Road #23, Chandler, AZ 85224 Ph: (480) 917-1720
- o Mesa - 5233 E. Southern Ave. #104, Mesa, AZ 85206 Ph: (480) 830-2882
- o Gilbert - 754 S. Val Vista Drive #105, Gilbert, AZ 85296 Ph: (480) 497-2900
- o Phoenix - 2836 E. Indian School Rd. #A8, Phoenix, AZ 85016 Ph: (602) 840-0056
- o Tempe - 1855 E. Guadalupe Rd. #112, Tempe, AZ 85283 Ph: (480) 839-8552
- o Queen Creek - 21323 S. Ellsworth Loop Rd. #101, Queen Creek, AZ 85142 Ph: (480) 307-8440
- o Ocotillo - 2815 E. Ocotillo Rd. #4, Chandler, AZ 85249 Ph: (480) 781-2964
- o Desert Ridge - 21001 N. Tatum Blvd. #78-1640, Phoenix, AZ 85050 Ph: (480) 306-7832
- o Goodyear - 3301 N. Litchfield Road #200, Goodyear, AZ 85395 Ph: (623) 935-2929



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
1)	
2)	
3)	
4)	
5)	

Known Medical Conditions:

- _____
- _____
- _____
- _____
- _____

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

- _____
- _____
- _____
- _____

Do you suffer 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. **(P) for Patient or (F) for family

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

Past Health History: Please mark any condition you have now or had in the past

General	GU	Hematology	Cardiovascular	GI	Skin
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rash
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Leaky Bladder	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Itching
<input type="checkbox"/> Fever	<input type="checkbox"/> Blood in Urine	Endocrine	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Lesions
MSK	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Diarrhea	Neurological
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fainting	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Strength Loss
<input type="checkbox"/> Stiffness	ENT	Respiratory	<input type="checkbox"/> Swollen Ankles	Eyes	<input type="checkbox"/> Numbness
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Difficult Hearing	<input type="checkbox"/> Coughing	Females Only	<input type="checkbox"/> Glasses	<input type="checkbox"/> Tremors
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Abnormal Mammo	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Memory Loss
Psychiatric	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Difficult Breathing	<input type="checkbox"/> Abnormal Pap	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sinus Trouble		Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N		Frequency _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Sore Throat		If so, how far along? _____		
Patient Signature _____			Date _____		Dr Initials _____

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1st Chief Complaint: _____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

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 : _____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

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: _____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

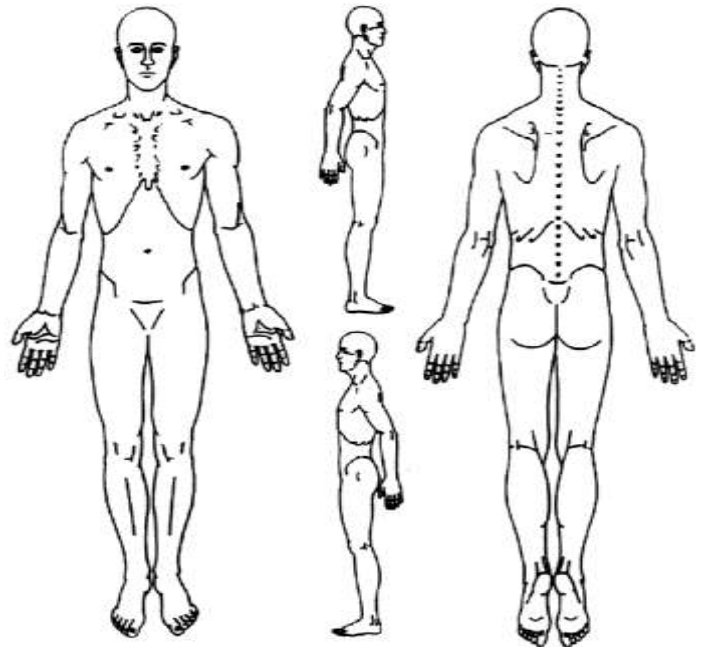
Circle the percentage of the day you experience the complaint:

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 where you are experiencing all 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



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

Do you have a pacemaker? Yes No

Do you drink alcohol? Yes No If Yes, what is frequency _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke? _____

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: _____

Patient Name (please print) _____

Patient Signature _____ Date _____

Dr. Initials _____