

OUTPATIENT THERAPY CENTER

653 Town Center Drive #117, Las Vegas, NV 89144
Main # (702) 233-7470 Fax # (702) 233-7426

PATIENT INFORMATION

Name _____ Social Security _____
Date of birth _____ Age _____ Male Female
Street Address _____ Apt. # _____
City/State/Zip _____
Cell Phone # _____ Home Phone # _____
 Married Single Widowed Divorced
Email _____
Employer _____ Title _____ Phone # _____
Emergency contact _____ Relationship _____
Phone # _____
Appointment reminder preference: Email Phone Call Text Message No Reminder

PRIMARY INSURANCE INFORMATION

Responsible Party Name _____ Relationship _____
Date of birth _____ Social Security _____
Employer _____ Phone # _____ Ext. _____
Title _____

SECONDARY INSURANCE INFORMATION

Responsible Party Name _____ Relationship _____
Date of birth _____ Social Security _____
Employer _____ Title _____


PHYSICIAN INFORMATION

Referring Physician _____ Surgeon _____

BAR CODE



HP1023


SUMMERLIN HOSPITAL
MEDICAL CENTER
PATIENT HISTORY
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(PMM# 78292000) (R 5/21) (FOD)

PATIENT IDENTIFICATION

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Are you currently receiving treatment from the following? (Please check.)

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Physical/Occupational therapist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Psychiatrist/Psychologist |

Please describe: _____

Have you or your immediate family ever been diagnosed with the following conditions?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other: _____ | | | |

Surgeries:

Please list any surgeries, hospitalization, and/or injuries with approximate date and reason:

Please list any allergies to medication: _____

Please list all prescription medications you are currently taking:

Have you taken any of the following over-the-counter medications in the last week?

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Antacid | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Mineral supplements | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Motrin | |
| <input type="checkbox"/> Other: _____ | | | |

Have you recently noted? Fatigue Nausea/vomiting Weakness
 Fever/chills/sweats Numbness/tingling Weight loss/gain

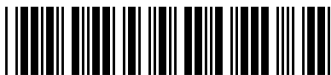
How much caffeinated coffee or caffeine beverages do you drink per day? _____

How many packs of cigarettes do you smoke per day? _____

How many days per week do you use marijuana? _____

How many days per week do you drink alcohol? _____ drinks per sitting? _____

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