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 _____

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

☐ Chiropractor ☐ Medical Doctor (MD) ☐ Physical/Occupational therapist
☐ Dentist ☐ Osteopath ☐ Psychiatrist/Psychologist

Please describe: _____

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

☐ Anemia ☐ Circulation problems ☐ Headaches ☐ Multiple sclerosis
☐ Arthritis ☐ Depression ☐ Heart disease ☐ Rheumatoid arthritis
☐ Asthma ☐ Diabetes ☐ Heart problems ☐ Stroke
☐ Cancer ☐ Emphysema/Bronchitis ☐ Hepatitis ☐ Thyroid
☐ Chemical dependency ☐ Epilepsy ☐ Mental illness ☐ Tuberculosis
❑ 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?

☐ Advil ☐ Aspirin ☐ Laxatives ☐ Tylenol
☐ Antacid ☐ Decongestants ☐ Mineral supplements ☐ Vitamins
☐ Antihistamines ☐ Ibuprofen ☐ Motrin
❑ 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? _____