Revive Medical

Name:_____DOB:_____ Sex: ☐ Male ☐ Female
Home Phone:_____ Cell Phone:_____
Address: _____City: _____State:_____Zip: _____
Email: _____SS #/SIN:_____

Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
*Appointment Reminder Preference: (circle one) Text Message Phone Call Email Please no appointment reminder
How did you hear about Revive Medical? _____
Name of Person to contact in case of an emergency _____ Phone:_____

Responsible Party (if other than self)
Name of The Person responsible for this account _____Relationship to Patient_____
Address _____Phone _____ Email:_____

Do you have any Medical insurance? ☐ Yes ☐ No If Yes, please give the receptionist all medical insurance cards on your first appointment.

Past Medical History

Have you ever had the following? Circle, Yes or No. Leave Blank if uncertain.

Measles.....NO YES Mumps.....NO YES CHICKEN POX.....NO YES Whooping Cough..NO YES Scarlet Fever.....NO YES Diphtheria.....NO YES Small Pox.....NO YES Pneumonia.....NO YES	Arthritis.....NO YES Venereal Disease.....NO YES Anemia.....NO YES Bladder Infection....NO YES Epilepsy.....NO YES Migraine Headache NO YES Tuberculosis.....NO YES Diabetes.....NO YES	Cancer..... NO YES Polio..... NO YES Glaucoma..... NO YES Hernia.....NO YES Blood or Plasma Transfusion.....NO YES Back Trouble.....NO YES	High Blood Pressure..NO YES Low Blood Pressure..NO YES Hemorrhoids.....NO YES Asthma.....NO YES Hives of Eczema.....NO YES HIV & AIDS.....NO YES Infectious Mono....NO YES Bronchitis.....NO YES	Mitral Valve Prolapse..NO YES Stroke.....NO YES Hepatitis.....NO YES Ulcer.....NO YES Kidney Disease..NO YES Thyroid Disease..NO YES Bleeding Easily...NO YES

Other Disease Please List:_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

Current Medication:	Dose	Prescribing Doctor	Reason for Taking

Current Medical History:

1. Have you received **Physical Therapy** in the past year? **YES or NO** If yes, what is the name of the clinic where the Physical Therapy was performed?_____
2. Have you received **Chiropractic** care in the past year? **YES or NO** If yes, what is the name of the clinic or Chiropractor where the care was performed?_____
3. Have you been prescribed any **Pain Medications** in the past year? **YES or NO** If yes, what is the name of the doctor who prescribed them?_____
4. Have you received any **injections** to help with pain in the past year? **YES or NO** If yes, what doctor performed the injections?_____

If you answered yes to any of the above questions, In order to better serve you, Revive Medical may request your authorization to release any outside pertinent health records.

Patient Social History:

Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs: Never: _____ Type/Frequency: _____

Significant Family Medical History: (if any)

	Disease/Diseases	**If Deceased, Cause of Death**
Father		
Mother		
Siblings		
Children		

Indicate by circling any of the problems below you have experienced in the last 1-2 months

EYES/EARS/NOSE/RESPIRATORY:
Asthma
Stuffy Nose
Hay Fever
Sore Throat
Chronic Cough
Chest Congestion
Frequent Sneezing
Itchy Watery Eyes
Earache / Ear Infection
Itching
Shortness of Breath
Wheezing

NEUROLOGICAL:
Headaches
Migraines
Dizziness
Numbness
Tingling
Pins/Needles in Hands or Feet

MUSCULAR/SKELETAL:
Muscle Aches
Fibromyalgia
Arthritis
Joint Pain
Back Pain
Neck Pain
Hand/Arm Pain
Shoulder Pain
Hip Pain
Knee Pain
Foot/Ankle Pain

General:
Fatigue
Malaise
Weakness, Tired
Lightheadedness
Irritability
Constipation
Diarrhea
Feeling Foggy
Forgetfulness

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date