PATIENT NAME_____ DATE_____

MALE/FEMALE DATE OF BIRTH_____ AGE_____

ADDRESS_____ CITY_____

STATE_____ZIP CODE_____HOME PHONE_____

CELL PHONE_____EMAIL_____

SOCIAL SECURITY#_____-_____-_____SPORTS PLAYED_____

OCCUPATION_____EMPLOYER_____

HEIGHT _____WEIGHT_____SHOE SIZE_____SHIRT SIZE_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? *(Patient, Doctor,*

Facebook, etc.) _____

WHAT IS YOUR MAIN CONCERN TODAY?

_____

PLEASE LIST YOUR FAMILY DOCTORS NAME_____

ADDRESS_____

FAMILY DR PHONE #_____FAX#_____

MEDICATIONS _____

ALLERGIES _____ TOBACCO USE: YES NO

PAST SURGICAL HISTORY _____

TYPE OF ATHLETE_____

NAME & SCHOOL LOCATION _____

PROFESSIONAL ATHLETE TEAM & LOCATION _____

ATHLETIC TRAINERS NAME _____

RECENT ATHLETIC/ACADEMIC ACCOMPLISHMENTS _____ I, hereby give my permission to to administer the proper care necessary in the diagnosis and treatment of my condition. I understand I am financially responsible to for any balance that my insurance carrier does not pay. A copy of this signature is as valid as the original.

PATIENT SIGNATUREX_____DATE_____

THANK YOU FOR FILLING OUT THIS FORM AND CONGRATULATIONS FOR TAKING TIME TO INVEST IN YOURSELF!!!