NORTHLAND
PHYSICAL MEDICINE

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"A Team approach to YOUR health"

WELCOME TO OUR OFFICE!

Name _____

Address_____ City_____ State_____. Zip_____

Home Phone,_____ Cell Phone, _____ E-Mail

Birth date, _____ Age, _____ SS#, _____ Marital Status: M W D S

Employer, _____ Work Phone, _____ Occupation, _____.

Spouse Name, _____ Name & Birthdate of Primary Insured _____

Primary Care Medical Doctor — Name & Location, _____

Do you have a CareCredit Account: Yes / No Health Saving Account (HSA): Yes / No

Referral: Patient/Friend/Employee/Doctor/ Law Office/ Lawyer -Name:_____

How did you hear about us? Facebook: _____ Radio: _____ Website: _____ Seminar/Dinner/Lunch: _____ Walk-in: _____ Personal Injury: _____

Event: Name _____

Please describe the primary health complaint you are experiencing. _____

_____

How long have you had this condition? _____

Doctor treating condition: _____ Treatment Received:_____

Other Doctor: _____ Other Treatment:_____

Date of most recent x-rays:_____ Date of most recent MRI:_____

Past surgeries:_____

What medications are you currently taking and for what conditions?_____

_____ Medication Allergies: _____

Is this condition related to an automobile accident or injury suffered at your job? Yes / No

Are you or could you be pregnant? Yes / No

Please put an "X" next to any current conditions and a "P" next to any past conditions please mark Left or Right if applicable:

_____Hip Pain - R / L	_____ Digestive Problems	_____ Headaches	_____ Cancer	_____ Asthma
_____Foot Trouble - R / L	_____ High/Low Blood Pressure	_____ Ear Infection	_____ Tremors	_____ Stroke
_____ Knee pain – R / L	_____ Sinus Problems	_____ Allergies	_____ Arthritis	_____ Irritable
_____Shoulder Pain - R / L	_____ Trouble Sleeping	_____ Fractured Bones	_____ Fainting	_____Depression
_____ Back Pain - Upper / Lower	_____ Accidents/Falls	_____ Loss of Balance	_____ Anemia	_____Hypertension
_____ Jaw Pain/TMJ - R / L	_____ Pain w/ Cough/Sneeze	_____Skin Problems	_____ Dizziness	_____Ulcers
_____Ringing in Ears - R / L	_____ Difficulty Breathing	_____Heart Problems	_____ Chest Pain	_____ Diabetes

Cancer Type: _____

*Treatment:*_____

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date_____