TRAGER HEALING

MEDICAL HISTORY:	
Name:	Today's Date:
Address:	Home Phone:
City, State, Zip:	Cell Phone:
Date of Birth: Age:	E-Mail:
Referred By: ❑ Other Physician ❑ Family Member ❑ Friend ❑ Insurance ❑ Other	

IN CASE OF EMERGENCY, CONTACT:	Name: *Relationship to Patient:*
Home Phone:	Cell Phone:

INSURANCE INFORMATION:	
Who is responsible for this Account?	*Relationship to Patient:*
Date of Birth:	S.S. #:

MEDICARE Information	Medicare I.D. #

BLUE CROSS BLUE SHIELD - PPO (We only accept BCBS PPO. We do not accept BCBS PPO CHOICE)	
Subscriber Name:	*Relationship to Patient:*
BCBS I.D. #: Group #:	Birth Date: S.S. #:

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with: _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The doctor may use my healthcare information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

SIGNATURE (Patient, Parent, or Guardian):	**PRINT NAME:**
Date:	*Relationship to Patient:*

ALLERGIES / DRUG INTOLERANCE:

HOSPITALIZATIONS, Including Surgery: (Do not list pregnancy unless you had a Cesarean Section)

Reason	*Date*	*Reason*	*Date*
1.		3.	
2.		4.	

WOMEN ONLY:	**Pregnant?** ❑Yes ❑No **Planning Pregnancy?** ❑Yes ❑No

IMMUNIZATIONS (year last received if known):

	Influenza (Flu)		Hepatitis B		Pneumonia		Tetanus		Zoster / Shingles		HPV

SOCIAL HISTORY:	**Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widow
Place of Birth:	**Occupation:**
Ethnicity: ❑White ❑Black/African American ❑Hispanic/Latino ❑American Indian/Alaska Native ❑Asian ❑Native Hawaiian/other Pacific Islander	

HABITS:

	Smoke: *Number of Packs/Day:*		*How Long:*	*Date Quit:*		*Interested in stopping?* ❑Yes ❑No	
	Coffee: *Cups Daily:*		**Tea:** *Cups Daily:*			Other Caffeine:	
	Alcohol: *Type:*		*Amount:*			*Frequency:*	
	Exercise: *Type:*					*Frequency:*	
	Diet: *Calories Daily:*		*Salt or Fat Restriction?:* ❑ Yes ❑No			*Amount:*	
	Contact with Blood/Bodily Fluid at work?:						
	Substance Abuse?:					**Other:**	

PAST MEDICAL HISTORY: (Please check which of the following problems you have had and indicate the year)

☐	Hypertension	☐	Cancer	☐	Venereal Disease
☐	Stroke / TIAs	☐	Hyperlipidemia	☐	Anemia
☐	Epilepsy / Seizures	☐	Congestive Heart Failure	☐	Gout
☐	Gout	☐	Arrhythmia	☐	Scarlet Fever
☐	Kidney Disease	☐	Allergies / Hay Fever	☐	Rheumatic Fever
☐	Thyroid Disease	☐	Asthma	☐	Diabetes
☐	Heart Murmur	☐	COPD	☐	Endocrine Disease
☐	Arrhythmia	☐	Liver Disease	☐	Arthritis
☐	Dizziness / Fainting	☐	Gastric Ulcer	☐	Osteoporosis
☐	Pneumonia	☐	GI Disorder	☐	Anxiety Disorder
☐	Stroke	☐	Sexual Dysfunction	☐	Other:
☐	MI / Heart Disease	☐	Menstrual Disorder	☐	Other:

MEDICATIONS & VITAMINS/HERBS: (Please list all you are currently taking, including Birth Control Pills)

Medication / Vitamin Name	Dosage and Frequency	When did you start the Medication / Vitamin?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

FAMILY HISTORY:

	FATHER		MOTHER		SIBLINGS		CHILDREN	OTHER
☐	Heart Disease	☐	Heart Disease	☐	Heart Disease	☐	Heart Disease	
☐	High Blood Pressure	☐	High Blood Pressure	☐	High Blood Pressure	☐	High Blood Pressure	
☐	Stroke	☐	Stroke	☐	Stroke	☐	Stroke	
☐	Cancer	☐	Cancer	☐	Cancer	☐	Cancer	
☐	Glaucoma	☐	Glaucoma	☐	Glaucoma	☐	Glaucoma	
☐	Diabetes	☐	Diabetes	☐	Diabetes	☐	Diabetes	
☐	Epilepsy	☐	Epilepsy	☐	Epilepsy	☐	Epilepsy	
☐	Bleeding Disorder	☐	Bleeding Disorder	☐	Bleeding Disorder	☐	Bleeding Disorder	
☐	Kidney Disorder	☐	Kidney Disorder	☐	Kidney Disorder	☐	Kidney Disorder	
☐	Thyroid Disease	☐	Thyroid Disease	☐	Thyroid Disease	☐	Thyroid Disease	
☐	Mental Illness	☐	Mental Illness	☐	Mental Illness	☐	Mental Illness	
☐	Parkinson's Disease	☐	Parkinson's Disease	☐	Parkinson's Disease	☐	Parkinson's Disease	
☐	Alzheimer's Disease	☐	Alzheimer's Disease	☐	Alzheimer's Disease	☐	Alzheimer's Disease	
☐	Osteoporosis	☐	Osteoporosis	☐	Osteoporosis	☐	Osteoporosis	
☐	***Diseased Age:***	☐	***Diseased Age:***	☐	***Diseased Age:***	☐	***Diseased Age:***	

PATIENT CONDITION:

Reason for Visit:

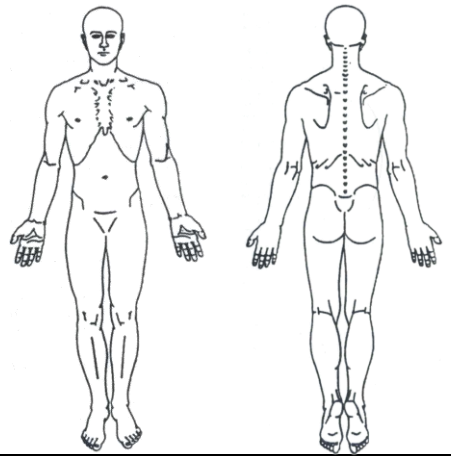
When did Symptoms Appear?:

Is this Condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of Pain:
❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other



How often to do you have the pain? Is it constant or does it come and go?

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down