



Date: _____

A. ABOUT YOU

1. What do you prefer to be called: _____ 2. -Male - Female;

3. Birthdate: _____ / _____ / _____ 4. SS #: _____

5. Mailing Address: _____

 _____ City _____ State _____ Zip _____

6. Home Phone: _____ 7. Other (cell / pager) Phone(s): _____

8. Employer: _____

9. Occupation: _____ 10. Work Phone: _____

11. Marital Status: Single, Married, Divorced, Separated, Widowed Spouse Name: _____

12. Who is your Primary Care Physician? : _____

13. Phone #: _____

14. Would you like to A. Receive our e-mail newsletter? - YES, - NO.
 B. Be a friend of Dr. Carter's office on Facebook? - YES, - NO.

15. E-mail Address: _____ 16. Face Book Name: _____

B. INSURANCE

NO INSURANCE COVERAGE

1. Auto Insurance: _____ Insured: _____
 Policy Number: _____ Claim Number: _____

2. Health Insurance: _____

C. IN THE EVENT OF AN EMERGENCY

1. Who should we contact? : _____

2. Relationship: _____

3. Home Phone #: _____ 4. Work Phone #: _____

D. AFFIRMATION

The above information is true and correct to the best of my knowledge:

X _____ Date: _____ / _____ / _____
 Signature

Official Use Only:

Primary Insurance Carrier: _____ copy of card provided
 Address: _____
 Claim #: _____ Policy Number: _____
 Coverage: _____ Adjuster Name: _____
 Insurance Phone #: (____) _____ Insurance Fax #: (____) _____

Secondary Insurance Carrier: _____ copy of card provided
 copy of card NOT provided
 ID #: _____ Effective Date: _____ Co-pay: _____
 Attorney Name: _____ Attorney Phone #: _____
 Verified by: _____ Date: _____

Date : _____



F. PAST ACCIDENT HISTORY	
1. Have you ever been in a previous accident? <input type="checkbox"/> YES, <input type="checkbox"/> NO:	
***** If YES, OFFICE STAFF TO FILL OUT ONLY*****	
G. MEDICATIONS - PRE-ACCIDENT	
1. List medications and dosages:	
2. Are you taking any vitamins, herbs or diet pills? <input type="checkbox"/> YES, <input type="checkbox"/> NO, If yes what:	
3. Allergies: <input type="checkbox"/> Yes, <input type="checkbox"/> No Drug & Reaction:	
H. MEDICAL HISTORY- PRE-ACCIDENT	
1. Head, Eyes, Ears, Nose, Throat: <input type="checkbox"/> N/A <input type="checkbox"/> vision change; <input type="checkbox"/> hearing change; <input type="checkbox"/> frequent nose bleeds; <input type="checkbox"/> recurrent sinus pain/discharge; <input type="checkbox"/> allergic rhinitis; <input type="checkbox"/> glaucoma; <input type="checkbox"/> macular degeneration; <input type="checkbox"/> cataracts Comments:	
2. Cardiac: <input type="checkbox"/> N/A <input type="checkbox"/> chest pain; <input type="checkbox"/> palpitations; <input type="checkbox"/> hypertension; <input type="checkbox"/> high cholesterol; <input type="checkbox"/> shortness of breath at night; <input type="checkbox"/> short of breath with exertion; <input type="checkbox"/> heart attack; <input type="checkbox"/> fainting episodes. Comments:	
3. Pulmonary: <input type="checkbox"/> N/A <input type="checkbox"/> shortness of breath; <input type="checkbox"/> chronic or recurrent cough; <input type="checkbox"/> chronic hoarseness; <input type="checkbox"/> chronic productive cough; <input type="checkbox"/> emphysema/COPD; <input type="checkbox"/> asthma; <input type="checkbox"/> bloody sputum; <input type="checkbox"/> toxic inhalant exposure. Comments:	
4. Gastrointestinal: <input type="checkbox"/> N/A <input type="checkbox"/> Ongoing nausea or vomiting; <input type="checkbox"/> diarrhea; <input type="checkbox"/> constipation; <input type="checkbox"/> abdominal pain. <input type="checkbox"/> blood in stool; <input type="checkbox"/> trouble swallowing; <input type="checkbox"/> marked reflux/GERD; <input type="checkbox"/> vomiting blood; <input type="checkbox"/> peptic ulcers; <input type="checkbox"/> jaundice; <input type="checkbox"/> pancreatitis; <input type="checkbox"/> bad hemorrhoids. <input type="checkbox"/> diagnosed diverticulitis	
5. Genitourinary: <input type="checkbox"/> N/A <input type="checkbox"/> trouble urinating; <input type="checkbox"/> blood in urine; <input type="checkbox"/> bladder infections (women > 4/year); <input type="checkbox"/> frequent urination at night; <input type="checkbox"/> kidney stones; <input type="checkbox"/> kidney failure; <input type="checkbox"/> stress/spastic incontinence.	
6. Males: <input type="checkbox"/> N/A <input type="checkbox"/> prostatitis; <input type="checkbox"/> prostate cancer; <input type="checkbox"/> testicular pain; <input type="checkbox"/> erection issues.	
7. Musculoskeletal: <input type="checkbox"/> N/A <input type="checkbox"/> bone pain; <input type="checkbox"/> joint pain; <input type="checkbox"/> muscle pain; <input type="checkbox"/> fractures/breaks; <input type="checkbox"/> wear and tear arthritis; <input type="checkbox"/> rheumatoid or other autoimmune disease; <input type="checkbox"/> swollen joints; <input type="checkbox"/> reddened joints. <input type="checkbox"/> Scoliosis <input type="checkbox"/> Osteoporosis/degenerative processes	
8. Endocrine/glands: <input type="checkbox"/> N/A <input type="checkbox"/> hypoglycemia; <input type="checkbox"/> adult diabetes; <input type="checkbox"/> juvenile diabetes; <input type="checkbox"/> thyroid disease; <input type="checkbox"/> gout; <input type="checkbox"/> Hyperglycemia; <input type="checkbox"/> pituitary dysfunction.	
9. Neurologic: <input type="checkbox"/> N/A <input type="checkbox"/> Seizures; <input type="checkbox"/> Stroke; <input type="checkbox"/> Confusion episodes; <input type="checkbox"/> Tremor; <input type="checkbox"/> Nerve pain; <input type="checkbox"/> Parkinson's; <input type="checkbox"/> Numbness; <input type="checkbox"/> Muscle Weakness; <input type="checkbox"/> Migraines; <input type="checkbox"/> Alzheimer's Ds.	
10. Dermatologic: <input type="checkbox"/> N/A <input type="checkbox"/> Skin Cancer/Pre-cancer; <input type="checkbox"/> Eczema; <input type="checkbox"/> Psoriasis; <input type="checkbox"/> Recurrent Allergic Rashes; <input type="checkbox"/> Hives; <input type="checkbox"/> Shingles; <input type="checkbox"/> Hair or Nail Changes; <input type="checkbox"/> Other Skin Conditions.	
11. Hematological/Lymphatic: <input type="checkbox"/> N/A <input type="checkbox"/> Anemia-Iron deficiency/ Other; <input type="checkbox"/> Malignancy; <input type="checkbox"/> Enlarged Lymph Nodes; <input type="checkbox"/> Bleeding Disorders- <input type="checkbox"/> Easy Bleeding/ <input type="checkbox"/> Clotting-Thrombosis.	

Date : _____



I PAST- SURGICAL HISTORY / OB GYN / PSYCHIATRIC			
1. Surgical history:			
2. Females: LMP _____ ; <input type="checkbox"/> BCP/IUD ; _____ #Children; <input type="checkbox"/> N/A <input type="checkbox"/> breast mass/discharge/pain;			
<input type="checkbox"/> abnormal/painful menses; <input type="checkbox"/> menopause. <input type="checkbox"/> Gravita/ para			
3. Psychiatric: <input type="checkbox"/> N/A, <input type="checkbox"/> Depression, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Behavior Changes, <input type="checkbox"/> Irritability,			
<input type="checkbox"/> Unkept, <input type="checkbox"/> Mood / Affect, <input type="checkbox"/> Orientation			
Mental Health Additional Information:			
Medical History Comments:			
J. FAMILY HISTORY			
1. Family History (Hereditary conditions, conditions that may effect manipulation)			
<input type="checkbox"/> Diabetes, <input type="checkbox"/> Cancer, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Cholesterol, <input type="checkbox"/> Arthritis, <input type="checkbox"/> Stroke <input type="checkbox"/> HBP			
Other:			
K. WORK HISTORY			
1. DISABILITY:			
A. As a result of this accident/injury, have you missed any work? <input type="checkbox"/> YES, <input type="checkbox"/> NO			
Give details/dates missed:			
B. As a result of the accident have you been placed on disability? <input type="checkbox"/> YES, <input type="checkbox"/> NO, if yes by whom?			
C. Before the accident, were you placed on any type of disability status? <input type="checkbox"/> YES, <input type="checkbox"/> NO			
Explain:			
2. While in recovery, is there light duty you could request? <input type="checkbox"/> YES, <input type="checkbox"/> NO, <input type="checkbox"/> N/A			
3. Occupation: current:			
4. Hours / Shift: _____ ; Shifts / Week: _____ ; Nights / Weekends:			
5. Indicate job duties and activities which you are occasionally asked to perform: <input type="checkbox"/> standing, <input type="checkbox"/> driving, <input type="checkbox"/> sitting,			
<input type="checkbox"/> twisting, <input type="checkbox"/> work with arms above head, <input type="checkbox"/> walking, <input type="checkbox"/> crawling, <input type="checkbox"/> typing, <input type="checkbox"/> lifting, <input type="checkbox"/> bending,			
<input type="checkbox"/> stooping <input type="checkbox"/> operating equipment. Other:			
6. Prior to the injury were you capable of working on an equal basis with others your age? <input type="checkbox"/> YES, <input type="checkbox"/> NO, <input type="checkbox"/> N/A			
7. Can others help you with any heavy lifting? <input type="checkbox"/> YES, <input type="checkbox"/> NO, <input type="checkbox"/> N/A			
8. Additional Info:			
L. EDUCATION / MILITARY / SOCIAL			
1. Education: Highest Level: <input type="checkbox"/> High School, <input type="checkbox"/> - Undergraduate Degree			
2. Military: <input type="checkbox"/> YES, <input type="checkbox"/> NO, If Yes, Branch and length of service:			
3. Who do you live with? <input type="checkbox"/> - Self <input type="checkbox"/> Other:			
4. Alcohol: <input type="checkbox"/> Yes, <input type="checkbox"/> No If yes How much, how often:			
5. Do you smoke / use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> NO. If so, how much? _____ How long? _____ Type? _____			
6. Sleep: <input type="checkbox"/> Poor Sleeper, <input type="checkbox"/> Sleep well			
7. Emotional State: <input type="checkbox"/> Nervous, <input type="checkbox"/> Average, <input type="checkbox"/> Depressed			
Additional Info:			
8. Activities of Daily Living Restrictions			
a. Self Care, Personal Hygiene: <input type="checkbox"/> -None, Comments:			
b. Communication: <input type="checkbox"/> -None,			
c. Occupational: <input type="checkbox"/> -None,			
d. Recreational: <input type="checkbox"/> -None,			
e. Home Responsibilities: <input type="checkbox"/> -None,			
f. Travel: <input type="checkbox"/> -None,			
g. Sexual Function: <input type="checkbox"/> -None,			