OUTPATIENT THERAPY CENTER

8686 West Patrick Lane, Las Vegas, NV 89148
Main # (702) 777-7171 Fax # (702) 777-7170

PATIENT INFORMATION

Name ______________________ Social Security ______________

Date of birth ______________ Age ______ ❑Male ❑Female

Street Address ______________________ Apt. # ________

City/State/Zip ______________________

Cell Phone # ______________ Home Phone # ______________

❑ Married ❑ Single ❑ Widowed ❑ Divorced

Email ______________________

Employer ______________ Title ______________ Phone # ________

Emergency contact ______________ Relationship ______________

Phone # ______________________

Appointment reminder preference: ❑ Email ❑ Phone Call ❑ Text Message ❑ No Reminder

PRIMARY INSURANCE INFORMATION

Responsible Party Name ______________________ Relationship ______________

Date of birth ______________ Social Security ______________

Employer ______________ Phone # ______________ Ext. ________

Title ______________________

SECONDARY INSURANCE INFORMATION

Responsible Party Name ______________________ Relationship ______________

Date of birth ______________ Social Security ______________

Employer ______________ Title ______________

PHYSICIAN INFORMATION

Referring Physician ______________________ Surgeon ______________

BAR CODE

HP1023

Valley Health
SURGERY *and* REHAB HOSPITAL
A Member of The Valley Health System

PATIENT HISTORY

(PMM# 55846) (R 7/21) (FOD)

PATIENT IDENTIFICATION

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Are you currently receiving treatment from the following? (Please check.)

- ❑ Chiropractor
- ❑ Medical Doctor (MD)
- ❑ Physical/Occupational therapist
- ❑ Dentist
- ❑ Osteopath
- ❑ Psychiatrist/Psychologist

Please describe: ______________________________

Have you or your immediate family ever been diagnosed with the following conditions?

- ❑ Anemia
- ❑ Circulation problems
- ❑ Headaches
- ❑ Multiple sclerosis
- ❑ Arthritis
- ❑ Depression
- ❑ Heart disease
- ❑ Rheumatoid arthritis
- ❑ Asthma
- ❑ Diabetes
- ❑ Heart problems
- ❑ Stroke
- ❑ Cancer
- ❑ Emphysema/Bronchitis
- ❑ Hepatitis
- ❑ Thyroid
- ❑ Chemical dependency
- ❑ Epilepsy
- ❑ Mental illness
- ❑ Tuberculosis
- ❑ Other: ______________________________

Surgeries:

Please list any surgeries, hospitalization, and/or injuries with approximate date and reason:

____
____
____

Please list any allergies to medication: ______________________________

Please list all prescription medications you are currently taking:

____
____
____

Have you taken any of the following over-the-counter medications in the last week?

- ❑ Advil
- ❑ Aspirin
- ❑ Laxatives
- ❑ Tylenol
- ❑ Antacid
- ❑ Decongestants
- ❑ Mineral supplements
- ❑ Vitamins
- ❑ Antihistamines
- ❑ Ibuprofen
- ❑ Motrin
- ❑ Other: ______________________________

Have you recently noted?

- ❑ Fatigue
- ❑ Nausea/vomiting
- ❑ Weakness
- ❑ Fever/chills/sweats
- ❑ Numbness/tingling
- ❑ Weight loss/gain

How much caffeinated coffee or caffeine beverages do you drink per day? ______
How many packs of cigarettes do you smoke per day? ______
How many days per week do you use marijuana? ______
How many days per week do you drink alcohol? ______ drinks per sitting? ______