iconmed **DAVID L. WALTERS, D.O.**

PATIENT REGISTRATION AND HISTORY

Date: Patient #:

Patient Information

Name_____
Address_____
City_____ State____ Zip_____
Home Phone (_____)_____
Cell Phone (_____)_____
E-Mail _____
Sex: M__F__ Age_____ Birth Date_____
Single___ Married___ Widowed___ Divorced___
Height_____ Weight_____
Patient SS#_____(required)
Occupation_____
Employer_____
Employer Phone_____
Spouse's Name_____
Birth Date _____
Occupation_____
Spouse's Employer_____
How were you referred to iconmed?
_____

In Case of Emergency, Contact:

Name_____
Relation_____
Home Phone_____
Work Phone_____
Cell Phone_____

Financial Statement

Responsible party_____
Birth Date _____SS#_____
Relationship to Patient_____

I understand that I am financially responsible for all charges for services at the time of the services.

._____
Responsible Party Signature Date

Patient Condition and Symptoms

Reason for visit _____
When did your symptoms appear?_____ Is this condition due to an accident?_____
Is this condition getting progressively worse? Yes____ No____ Unknown____

Rate the severity of your pain 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 do you have this 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

What treatment have you already received for your condition? None___ Medication___ Surgery___
Physical Therapy___ Chiropractic Services___ Other_____

Name and address of other doctor(s) who have treated you for your condition:
._____
._____