New Patient Questionnaire

Today's Date: ____ / ____ / _____ **Signature of Patient:**_____

PATIENT HEALTH HISTORY & CONFIDENTIAL INFORMATION

Patient Title: (circle one): Mr Mrs Ms Miss Dr. Prof Rev.

First Name: **Nick Name**:

Last Name: **Middle Name**: **Suffix**:

Address

City **State** **Zip Code**

Primary Phone: **Secondary Phone**:

Mobile Phone

Home email: **Work Email**:

How did you hear about us? ☐ Facebook ☐ phone book ☐ website ☐ newspaper
☐ Referral (please include referral name if possible) _____

Employer **Phone**

Employer Address **Occupation**

Spouse: **Phone**

Emergency Contact **Phone**

Contact method: *Please check which of the following contact methods is best to reach you*
☐ Primary Phone ☐ Secondary phone ☐ Mobile phone

Gender:(check one) ☐ M ☐ F ☐ unspecified

Patient Date of Birth: ____/____/_____ **Age**:

Marital Status (check one) single married other SSN_____

Employment status: (circle one)
Employed FT student PT student other retired self employed

Race: (circle one)

White	black/African American	Hispanic	American Indian/Alaskan
Asian	asian Indian	Chinese	filipino
Japanese	Korean	Vietnamese	Native Hawaiian/oth Pacific Isl.
Samoan	Guamanian or Chamorro	other	choose not to specify

Multi- racial (*check one*) ☐ yes ☐ no ☐ unknown

Ethnicity (*circle one*) Hispanic or Latino non Hispanic or Latino choose not to specify

Preferred language (check one) English Spanish Choose not to specify other

Verification question: What is your mothers maiden name?

Do you currently smoke tobacco of any kind? ☐ Yes ☐ former smoker (Date quit: _____)
☐ Never been a smoker

If yes, how much do you currently smoke: ☐ 1-10 cigarettes/ day ☐ 10-20 cigarettes/day
☐ More than 20/day

If yes, what is you level of interest in quitting smoking?

0 1 2 3 4 5 6 7 8 9 10
No interest very interested

Current Medications, including frequency and dosage if known.
If there are no current medications, check this box ☐

Medication	Start Date	Medication	Start date

List any known allergies you have had to any medications, supplements, etc.
If no allergies known, check here. ☐

1. 3.
2. 4.

Briefly list any major surgeries you may have had, or any major health problems.

1. 3.
2. 4.

Has any doctor diagnosed you with hypertension (high blood pressure) presently? ☐ Yes ☐ No

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes what kind? ☐ Type 1 ☐ Type II
If yes to diabetes, was your blood lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not sure
If yes other comments regarding Diabetes:

Have you had an X-ray or CT scan or MRI of your spine in the past year? ***(circle one)*** Yes no
If so, <u>where</u> were they taken?

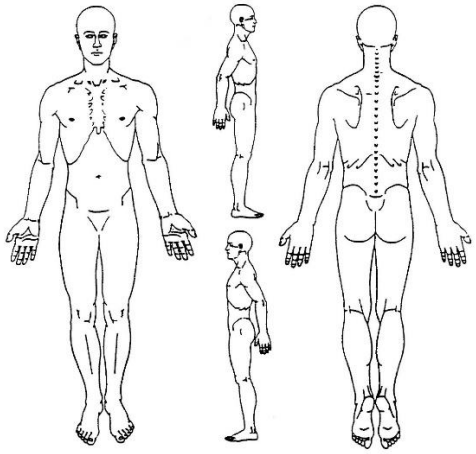
Family and personal history
Please list immediate family members (or yourself) who have the following conditions:

Cancer	Liver Disease
Diabetes	Mental illness
Heart disease	Thyroid disease
High blood pressure	Arthritis
Stroke	Asthma
Alzheimers	Allergies

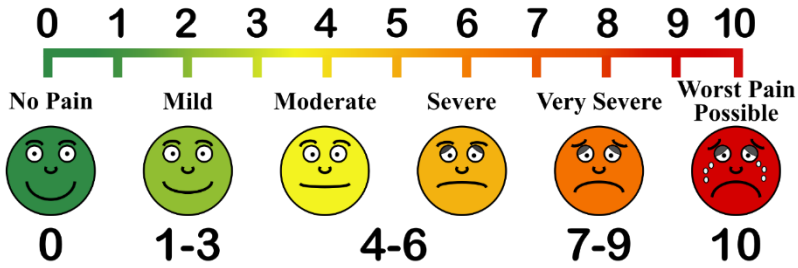
FOR WOMEN ONLY:

Are you pregnant? Yes No If so how many weeks? _____
Are you currently nursing? Yes No
Are you taking birth control Yes No

Place an " X " on the drawings to the left wherever you have pain. Mark an "O" for past conditions or issues.



Please rate your pain level(s). Indicate for what region if multiple affected.



Review of Body Systems:

A full review of systems of the body helps us to get a full picture of your health. Please let us know if you have any of the issues below or specify that you don't have any complaints in those areas of your body.

Circle all that apply Below:

Acne	Diabetes	Immune disorders	poor circulation
Angina	Diarrhea	Infertility	prostate issues
Ampysema	Dizziness	kidney stones	psoriasis
Anorexia/bulimia	Eczema	loss of smell	rash
Anxiety	Erectile dysfunction	loss of taste	ringing in the ears
Apnea	Excessive bruising	low blood pressure	scoliosis
Arthritis	Fainting	low energy	shortness of breath
Asthma	Fatigue	low libido	skin cancer
Back problems	Food sensitivities	neck pain	stroke
Bedwetting	Frequent infection	numbness	sudden weight gain/loss
Blurred vison	Hair loss	osteoporosis	swollen glands
Cancer	Heartburn	pins and needles	thyroid issues
Chronic ear infection	High blood pressure	PMS symptoms	TMJ issues
Constipation	High cholesterol	pneumonia	Ulcer
Depression	Hypoglycemia	poor appetite	Weakness

Please fill out the following page as thoroughly as possible

Problem Areas:

Please Describe your problem:

How did your problem begin?

Onset date (When did the problem start): _____

How often do you experience your symptoms?

Please describe the nature of your symptoms:

- ☐ Dull
- ☐ Throbbing
- ☐ Deep
- ☐ tingling
- ☐ cramping
- ☐ radiating
- ☐ sharp
- ☐ burning
- ☐ aching
- ☐ stabbing
- ☐ numbness
- ☐ other: _____

Radiation: Does it affect other areas of your body? If yes, to what areas does the pain radiate, shoot or travel?

What makes the pain BETTER?

What makes the pain WORSE?

What have you done thus far in attempts at relieving your symptoms?

- ☐ Prescription medication
- ☐ Massage
- ☐ Physical therapy
- ☐ Other _____
- ☐ chiropractic
- ☐ homeopathic remedies
- ☐ heat
- ☐ acupuncture
- ☐ over the counter drugs _____
- ☐ ice
- ☐ surgery

Please let us know any additional information pertinent to your issue below:

To be performed by clinic Staff:

Height : **Weight :** **Blood pressure: /**

INSURANCE INFORMATION

(if you are not utilizing insurance please leave this page blank)_

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident
___ Medical Savings Account & Flex Plans ___ Personal Injury ___ Other

***Please indicate which is **Primary** and **Secondary** if applicable*

INSURANCE AUTHORIZATION AND RELEASE

*****Please carefully read the following and sign below*****

**I certify that I have read and understand the provided insurance information to the best of my knowledge and the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.*
**I authorize the physician to release any information including my diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.*
**I authorize and request my insurance company to pay directly to the physician's office, insurance benefits that are otherwise payable to me.*
**I understand that my insurance carrier may pay less than the actual bill for services.*
**I understand that I am responsible for all copays, deductibles, co-insurance and balances.*

X _____
Signature of patient (or parent if minor)

PLEASE READ AND SIGN
(FOR EVERYONE)

** We invite you to discuss with us any questions regarding our services. The best services are based on a friendly mutual understanding between provider and patient*

** Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.*

**I understand that I am responsible for all copays, deductibles, co-insurance and balances.*

**I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.*

**As with any form of healthcare, some risks are present, and although non- intentional by the provider, I am aware of these risks. I acknowledge that I can ask the provider any and all questions I may have regarding my healthcare.*

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I provided.*

X _____ Date: ____/ ____/ ____
Signature of patient (or parent if minor) Relationship to patient: (circle one) Self Parent /Guardian Spouse

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Patient Name: X _____Patient # _____
(Last) (First) (Middle)

_____ I have received the _____Notice of Privacy Practices.

X _____
_____/_____/_____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Relationship to Patient Privacy Notice Version #

_____ _____
Witness Location Privacy Notice Written Acknowledgement was obtained (if more than one clinic location)

Documentation of Good Faith Effort

1. Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient, parent, legal guardian declines to acknowledge the receipt of the Notice of Privacy Practices.
2. Patient/parent/legal guardian states they has already received the Privacy Notice
3. Patient/Parent/legal Guardian directed our clinics website to view the Notice of Privacy Practices
4. The Notice of Privacy Practices was mailed to the patient/patent/legal guardian
5. Other _____

_____ _____
_____/_____/_____
Witness Date: