Today's Date: ___/___/___

☐ **New Patient** ☐ **Reactivate** ☐ **Change of Insurance effective ___/___/___**

Whole Body Health And Wellness

Name _____
Last First MI

Personal Information

Address _____ **Apt/Suite** _____

City _____ **State** _____ **Zip** _____

Home Phone (____) _____ **Cell Phone** (____) _____ **Email:**_____

Social Security# _____-_____-_____ **Birth Date:** _____/_____/_____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ **May we call you at work?** ☐ Yes ☐ No **Work Phone** (____) _____

Emergency Contact: _____ **Relationship to patient:** _____

Phone number: Home: (____) _____ **Work:** (____) _____**Cell:** (____) _____

Primary Care Physician (PCP) _____ **Address:** _____
Street, City, State, Zip

Phone: (____) _____ **Fax:** (____) _____

CONFIDENTIAL PATIENT HEALTH RECORD

Please describe the reason for your visit: _____
_____

How long have you had this problem? _____

Have you ever had this problem before? ☐ Yes ☐ No **If Yes, how many times?** _____

What caused your condition/symptoms? ☐ Auto Accident ☐ Work Accident ☐ Other/Unknown: _____

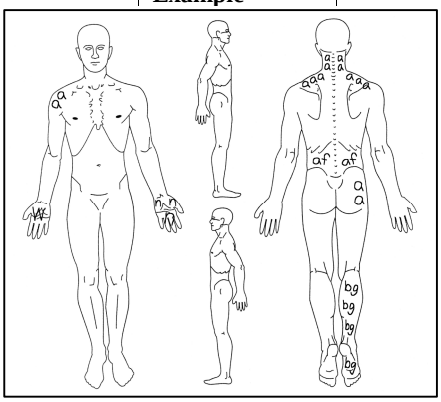
PAIN DIAGRAM

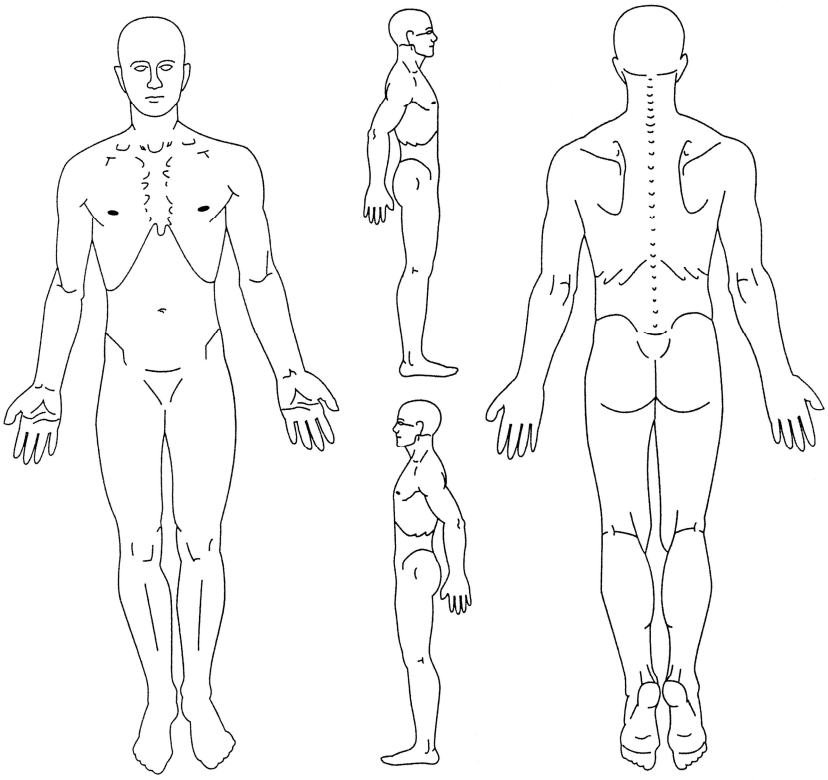
Report here the symptoms you feel at the present time. Mark the body area(s) with the type of symptoms, using the symbols in the key below. Then please fill in the additional information regarding your condition in the chart below.

SYMPTOM SYMBOLS

Aching	=	a
Burning	=	b
Numbness	=	n
Sharp	=	s
Stiffness	=	f
Tingling	=	g
Weakness	=	w

Example





AREA	Side: Left Side (L) Right Side or Both (B)	Pain Type: Aching (a), Burning (b) Numbness (n), Sharp (s) Stiff (f), Tingling (g) Weakness (w)	Pain Rating: Choose 0 (no pain) to 10 (intolerable pain)	Pain Frequency: Constantly (C) (76-100% of the time) Frequently (F) (51-75% of the time) Occasionally (O) (26-50% of the time) Intermittently (I) (1-25% of the time)	What aggravates the pain? Lifting, walking, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping	What relieves the pain? Lying down, heat, ice, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping
Low Back	*L*	*a , b*	*8*	*C*	*Bending forward, cough*	*Lying down, Ibuprofen*

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

PLACE A "C" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE CURRENTLY AND PLACE A "P" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE HAD IN A PAST

☐ I have not had, nor do I presently have, any of the following symptoms.

____ Allergies: (List Below)	____ Condition aggravated by coughing, sneezing, or grunting	____ Hemorrhoids	____ Prolonged steroid use
_____	____ Connective tissue disease	____ Hepatitis	____ Prostate Disease
_____	____ Type: _____	____ Hernia	____ Prostate problems
_____	Date diagnosed: ____/____/_____	____ Herniated disc	____ Prosthesis
_____	____ Constant pain unrelated to movement	____ High Blood Pressure	____ Psoriasis
____ Appendicitis	____ Constipation	____ High Cholesterol	____ Recent loss or blurring of vision
____ Arteriosclerosis	____ Dermatitis	____ History of malaise/generalized weakness	____ Urinary issues
____ Arthritis	____ Diabetes:	____ Jaw problems	____ Rheumatoid arthritis
____ Asthma	____ Type I	____ Joint swelling	____ Ringing/buzzing in the ears
____ Back pain	____ Type II (adult onset)	____ Kidney Disease	____ Sciatica
____ Blood in urine	____ Digestive problems	____ Liver Disease	____ Scoliosis
____ Blurred vision	____ Dizziness	____ Loss of memory	____ Shortness of breath
____ Burning, tingling, or numbness into the hips, legs, or feet	____ Epilepsy	____ Loss of smell or taste	____ Sinus problems
____ Burning, tingling, or numbness into the shoulders, arms, or hands	Fainting	____ Low Blood Pressure	____ SLE (Lupus)
____ Cancer (Benign or Malignant)	____ Fatigue	____ Low Blood Sugar	____ Sleeping difficulties
Type(s): _____	____ Fibromyalgia	____ Migraines	____ Tendonitis
Date diagnosed: ___/___/___	____ Fractures	____ Mononucleosis	____ Tension
____ Cataracts	Where: ____ When:	____ Mumps	____ Thyroid Disorder
____ Chest pain	____ Gall Bladder Problems	____ Muscular incoordination	____ Tooth Pain
____ Chicken Pox	____ Glaucoma	____ Nausea	____ Unexplained excessive thirst
____ Chronic back problems	____ Goiter	____ Nervousness	____ Unexplained loss of appetite
____ Chronic lung disease	____ Gout	____ Osteoporosis	____ Unexplained weight loss greater than 10 lbs.
___ Bronchitis	____ Hair loss	____ Pacemaker	____ Urethral discharge
___ Emphysema	____ Headaches	____ Painful urination	____ Vaginal infections
____ Cold feet	____ Heart attacks	____ Pinched nerve	____ Visual disturbances
____ Cold sweats	____ Heart Disease	____ Pneumonia	____ Whooping cough

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	Reason	Dosage (Example: 500mg)	Frequency (Example: 2x/day)	Is it helping?

Please check the boxes below to indicate how this condition has affected the following aspects of your life:

	Severely	Moderately	Mildly	Not at all
Quality of work				
Ability to do household chores				
Social life				
Family life				
Recreational activities				
Quality of sleep				

Has this condition affected your life in any other way? ☐ Yes ☐ No

If Yes, how: _____

_____

I understand that the information contained within this form is confidential. I certify that this form was completed correctly and to the best of my knowledge.

Patient/Guardian Signature: _____ Date: ____/____/_____

Financial Information

Cash (cash/check/credit card)

- **Check here if you will settle your payments privately rather than through a third party.**

Major Medical/Medicare **WE WILL NEED A COPY OF YOUR INSURANCE CARD.**

Name of the insured: _____

Relationship to patient: · Self · Spouse · Child · Other_____

Insured's Address_____ **Insured's SSN**_____-_____-_____

Insured's Employer_____ **Employer Address**_____

Name of Insurance Carrier_____ **ID**_____ **Group**_____ **Phone**_____

Name of Secondary Ins. Carrier_____ **ID**_____ **Group**_____ **Phone**_____

Workers' Compensation Claim

Date of Injury___/___/____ **Supervisor/HR Manager's Name**_____

Employer_____

Address_____ **Phone**_____ **Fax**_____

Name of Insurance Carrier_____ **Claim #**_____ **Phone**_____ **Fax**_____

(PERTAINS TO LIABILITY CLAIMS)

Auto Injury Insurance Medpay **WE WILL NEED A COPY OF THE POLICE REPORT.**

This information should reflect your personal Medpay policy

Were you the: · Driver · Passenger · Other_____

Owner of the vehicle: _____

Relationship to patient: · Self · Spouse · Child · Other_____

Insured's Address_____ **Insured's SSN**_____-_____-_____

Name of Insurance Carrier_____ **ID**_____ **Claim**_____ **Phone**_____

Is an attorney representing you? · Yes · No **Attorney's name**_____ **Law Firm**_____

Phone_____ **Fax**_____ **Address**_____

Authorization to Pay Physician *(insured patients)*

I certify that the insurance information I have provided is accurate and current. I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges not covered by my insurance.

Signature: _____ Date: ____/____/_____

Authorization

I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions as outlined in our HIPAA Privacy Notice and Consent Form.

I furthermore certify that all information I have provided that appears on this form is accurate as it is shown here.

Signature: _____ Date: ____/____/_____

Whom may we thank for referring you? _____