NEW PATIENT INFORMATION

Date___/___/_____

Name: ____
Last First MI

Email Address:____

Mailing Address:____

____

Phone #: C(___)____-__________ W(___)____-__________ Other(____)____-__________

Date Of Birth: ____/___/___ Sex: Male Female SS#______/______/_______

Martial Status: Single Married Divorce Widowed Separated Minor

How did you hear about our practice?____

Primary physician: ____________________________Type of Physican: _________________________

Physical Address: __________________________________ Phone# ( )____-_________________

Emergency Contact: Name:________________________ Relation:___________________________

Phone#: C ( ) _-_______W ( ) - _____Other ( ) - _____

Accident Information

Is this visit due to an accident? Yes No If yes, What type? Auto Work Other______

Has it been reported? Yes No If yes, to whom?_________________________________

Insurance Information

Do you have health insurance? Yes No Name of Carrier:__________________________

Do you have secondary insurance? Yes No Name of Carrier:__________________________

Name of person responsible for this account:____

If other than Self: Relationship to person:______________________ Phone#:( ) -__________

Policy Holder's Date of Birth:___/____/______ Policy Holder's SS#:-_____/___/_____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release: (insured patients)

I certify that I (or my dependent) have insurance coverage with __________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSCIAN/MEDICAL PRACTICE, MHMG INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

Patient Signature(X)____ Date_____/_____/_________

I. HEALTH HISTORY:

Please indicate if you have EVER been diagnosed with the following conditions.

	Acid Reflux		Food Allergies		Pacemaker
	AIDS/HIV		Glaucoma		Parkinson's Diease
	Alcoholism		Goiter		Peripheral Artery Disease
	Anemia		Gonorrhea		Phlebitis
	Anorexia		Gout		Pinched Nerve
	Anxiety		Heart Attack		Pneumonia
	Appendicitis		Heart Disease		Polio
	Arthritis		Hemochromatosis		Prostate Cancer
	Asthma		Hematomas		Prosthesis
	Blood Disorder		Hepatitis		Psychiatric Care
	Breast Cancer		Hernia		Rheumatic Fever
	Breast Lumps		Herniated Disc		Rhematoid Arthritis
	Bronchitis		Herpes		Scarlet Fever
	Bruise Easily		High Blood Pressure		Seasonal Allergies
	Bulimia		High Cholesterol		Seizures
	Cancer		Hypertension		Skin Condition
	Carpal Tunnel		Hypogonadism		Sleep Apnea
	Cataracts		Hypothyroidism		Stroke
	Chemical Dependency		Kidney Diease		Suicide Attempt
	Chicken Pox		Lactose Intolerance		Thyroid
	Cottonseed Allergy		Liver Disease		Tonsillitis
	Depression		Low Testosterone		Tuberculosis
	Diabetes Type I		Measles		Tumors/Growths
	Diabetes Type II		Migraines		Typhoid
	Emphysema		Miscarriage		Ulcers
	Enlarged Thyroid		Mononucleosis		Vaginal Infections
	Epilepsy		Multiple Sclerosis		Varicose Veins
	Erectile Dysfunction		Mumps		Verneral Disease
	Fever		Obesity		Whooping Cough
	Fibromyalgia		Osteoporosis		Other:

II. FAMILY HEALTH HISTORY:

Please indicate if a family member has been diagnosed with the following conditions.

	Breast Cancer		Endocrine Disease		Prostate Cancer
	Cardiovascular Disease		Heart Attack		Reproductive Disorder
	Delayed Puberty		Heart Disease		Stroke
	Diabetes		Hypothyroidism		Other:

III. LIFESTYLE:

a. Circle each option which best describes your exercise, nutrtion and lifestyle behavior.

Exercise	Daily	4-6 times per week	2-3 times/week	Once per week	Not often	Not at all
Drink Water	8 glasses per day	5-7 glasses per day	3-4 glasses per day	2 glasses per day	1 glass per day	Not sure
Eat Fast Food	Never	Once in a while	Once a month	Once a week	A few times per week	Every day
Drink Soda	Never	Once in a while	Once a month	Once a week	A few times per week	Once a day
Take A Multivitamin	Every day	Once a week	Once a month	When I remember	Not often	Never
Drink Coffee	Never	Not often	3-4 times per week	Every day	More than once a day	Multiple cups per day
Drink Alcohol	Never	Not often	1-2 times per week	3-4 times per week	Every day	Mutiple drinks per day
Sleep Less Than 7hrs	Never	Not often	Once in a while	Once a week	A few times per week	Every day
Smoke Cigarettes	Never	Not often	1-2 times per week	3-4 times per week	Every day	Mutiple times per day

b. Please RATE yourself on the following lifestyle factors using a scale of 1-10?
(1 = poor, 10 = excellent)

Exercise_____
Sleep_____
Diet_____

Stress Level_____
Water Consumption_____
General Health_____

IV SYMPTOMS:

a. Please CHECK to indicate if you are CURRENTLY experiencing any of the following symptoms:

	Abdominal Pain		Hair Loss		Pins & Needles (Arms)
	Acne Outbreaks		Hand Pain		Pins & Needles (Legs)
	Allergies		Headaches		Post Nasal Drip
	Altered Sense of Smell		Hearing Loss		Recurrent Rashes
	Anxiety		Heartburn		Red Eyes
	Arm or Leg Weakness		High Blood Pressure		Reflux
	Back Pain		Hives		Ringing in Ears
	Bad Breath		Hyperpigmentation		Runny Nose
	Bloating		Increased Blood Sugar		Shortness of Breath
	Blurry Vision		Insomnia		Shoulder Pain
	Breast Enlargement		Irritability		Shoulders Tension
	Breast Sensitivity		Itchy Eyes		Sinus Infections
	Bumpy Skin		Itchy Nose		Sleeping Difficulties
	Change in Appetite		Itchy Skin		Skin Discoloration
	Chest Pain or Pressure		Jaw Problems		Skin Redness
	Chronic Pain		Joint Pain		Skin Sensitivity
	Cold Feet		Knee Pain		Sneezing
	Decreased Appetite		Leg Pain		Snoring
	Decreased Libido		Light Sensitivity		Stiffness
	Depression		Loss of Smell		Stomach Problems
	Double Vision		Loss of Taste		Sudden Weight Loss/Gain
	Difficulty Breathing		Lower Back Pain		Suspicious Skin Lesions
	Difficulty Sleeping		Low Self Confidence		Swallowing Difficulties
	Difficulty Speaking		Memory Loss		Sweating Episodes
	Digestive Problems		Mood Swings		Swelling
	Discolored Mucus		Muscle Pain		Tension
	Dizziness		Muscle Weakness		Thinning Hair
	Dry skin		Nasal Congestion		Tingling
	Energy Loss		Nasal Polyps		Visual Disturbances
	Enlarged Pores		Nausea		Vomiting
	Excessive Thirst		Neck Pain		Weight Gain
	Fainting Spells		Nervousness		Weight Loss
	Fatigue		Night Sweats		Wrist/Arm Pain
	Fever		Nipple Tenderness		Other:
	Fine Lines & Wrinkles		Nose Bleeds		
	Foggy Thinking		Numbness		
	Foot/Ankle Pain		Palpations		
	Frequent Urination		Persistent Cough		

b. Please briefly elaborate on any symptoms you would like to discuss with the doctor today:

____
____
____
____
____
____
____
____
____

c. How often do you experience these symptoms? (i.e. Daily, Weekly, Monthly)

____
____

d. Has your symptom(s) been interfering with your life? What does your symptom prevent you from doing, either partially, totally, that you would really like to be doing again?

HOBBIES:____
WORK:____
SLEEP:____
Other:____
____
____

e. Is there any accident, injury, trauma, life event that you may or may not think is related? If yes, please describe.

____
____
____
____

f. How long have you had been experiencing these problems? _____ months/years
g. If you do nothing, do you think your problem will get ___ Better or ____ Worse?
h. h. Are you ready to make a CHANGE in the way you have been dealing with this problem?
   ____ Yes ____ No

i. How COMMITTED are you to getting rid of your problem? (Scale of 1-10, with 10 being the highest)

1 2 3 4 5 6 7 8 9 10