CORE|HEALTH|&|WELLNESS|CENTER

New Patient Intake

Please completely fill out all applicable information

Date · _____

Pt Name · _____, _____ _____
Last First Mid

SS# · _____ Gender · M F

DOB · _____

Address · _____ _____
Street Apt

_____
City State Zip

Phone · Home _____

· Work _____ Email · _____@_____

Occupation · _____ ~ Retired · ❑ No ❑ Yes, _____
When

Employer · _____

Marital Status · M / S / D / W / SEP Spouse's Name · _____

Emergency Contact Name/number · _____

(for minors < 18yo - if applies) Parent/ Guardian Signature · _____

How did you hear about the office?
❑ Ad ❑ Phone Book
❑Other _____
❑ Referral _____

Student · ❑ Yes ❑ No
Veteran · ❑ Yes ❑ No
❑ Active Duty

Initial Complaint · _____ (1)

List of other complaints · _____ (2)

_____ (3)

(Fill out for Complaint 1)

· Have you had this before? N Y · _____ (when)

· When did this happen? _____

· How did this happen? _____

_____

· What makes the pain *worse*? _____

· What makes the pain *better*? _____

· Please circle the character of your pain:

· Dull / Sharp
· Achy / Stabbing
· Deep / Superficial
· Numbness (pins&needles) / Burning

· Does the Pain travel down your arm / leg?

N Y, _____ (where)

· Please circle the pain's intensity · Slight Mild Moderate Severe

· How often does the pain occur?

· Intermediate (<1/4 of the time)
· Occasionally (1/4 – ½)
· Frequent (1/2 – ¾)
· Constant (3/4 – 100%)

· Have you lost sleep due to the pain: N Y

· Is the pain worse in: AM PM

· Does it interfere with your work and/or daily living? N Y

· Have you seen any other doctors for this condition?

N Y, (who, results) _____

Visual Analog Pain Severity Scale

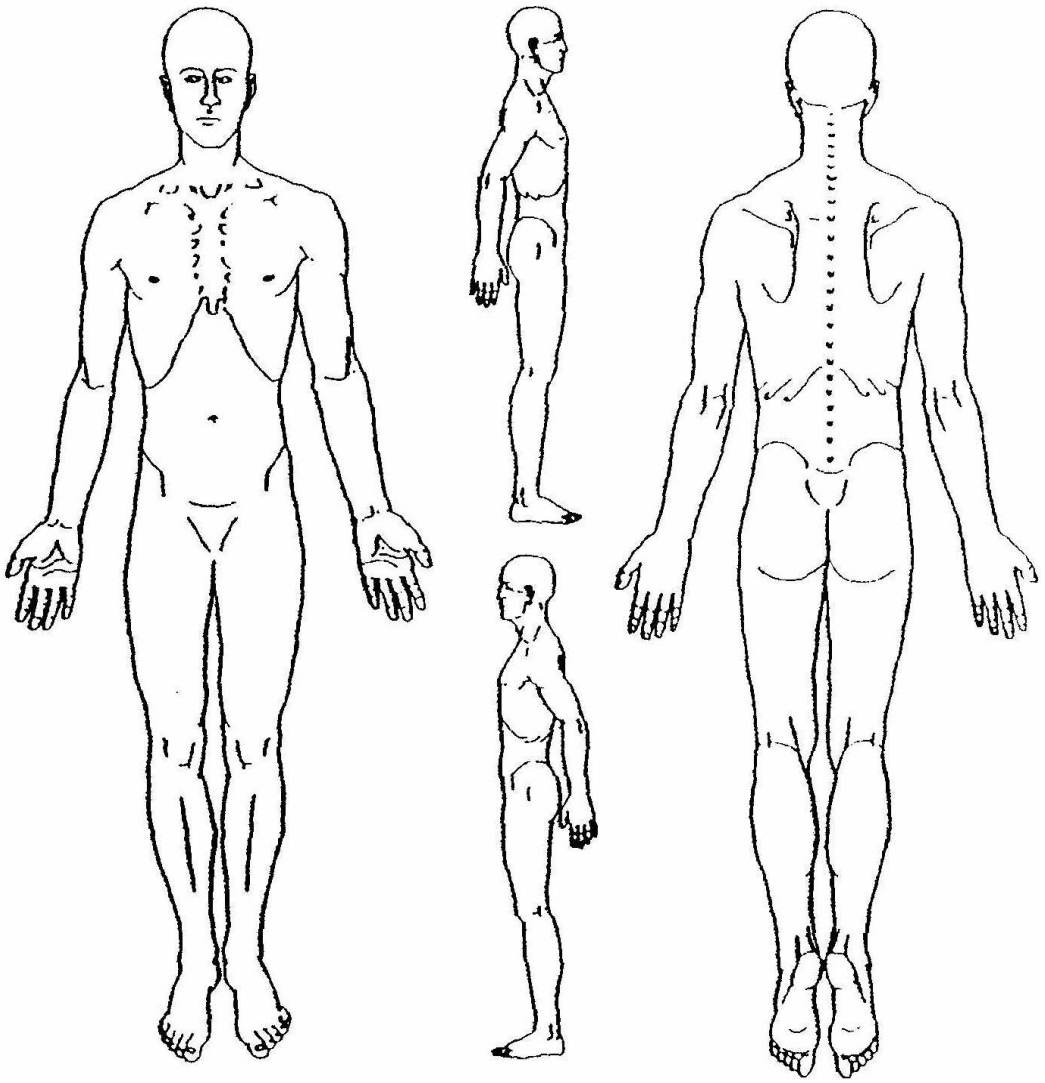
Instructions: please place a mark on the line that corresponds to how you presently feel.

NO PAIN ---------- Worst Pain Ever

Pain Diagram

On the diagram below, using the key, please indicate the location and type of pain you are currently experiencing

Key · A = Achiness B = Burning N = Numbness
X = Stabbing O = Pins and Needles



Pt Name: _____ Date: _____

· Please check any conditions that you have had or currently have:

(P= past C= Current)

P	C	Musculoskeletal
❑	❑	Low Back Pain
❑	❑	Arm Pain
❑	❑	Fracture/Dislocation
❑	❑	Trouble Swallowing
❑	❑	Joint Pain/Stiffness
❑	❑	Leg Pain
❑	❑	Neck Pain
❑	❑	Mid Back Pain
❑	❑	Muscle weakness

Nervous System

- ❑ ❑ Numbness
- ❑ ❑ Dizziness
- ❑ ❑ Fainting
- ❑ ❑ Loss of Balance
- ❑ ❑ Seizures
- ❑ ❑ Stroke
- ❑ ❑ Depressions
- ❑ ❑ Paralysis
- ❑ ❑ Headaches

Gastro-Intestinal

- ❑ ❑ Change in Appetite
- ❑ ❑ Food intolerance
- ❑ ❑ Nausea/ Vomiting
- ❑ ❑ Gallbladder problems
- ❑ ❑ Gas
- ❑ ❑ Constipation
- ❑ ❑ Abdominal Cramps
- ❑ ❑ Ulcers
- ❑ ❑ Diarrhea
- ❑ ❑ Hemorrhoids
- ❑ ❑ Liver Disease
- ❑ ❑ Black/ Bloody Stools

Genito-Urinal

- ❑ ❑ Excessive Urination
- ❑ ❑ Difficult Starting/Stopping
- ❑ ❑ Change in urine color
- ❑ ❑ Prostate: Last Exam: ____
- ❑ ❑ Discharge
- ❑ ❑ Urinary Tract Infections
- ❑ ❑ Flank/ Pelvic Pain
- ❑ ❑ Birth Control Pills
  - Type: _____
  - How long: _____
- ❑ ❑ Change in Sex Drive
- ❑ ❑ Pain During Sex
- ❑ ❑ Other _____
  _____

Cardio/Respiratory

- ❑ ❑ Shortness of Breath
- ❑ ❑ High Blood Pressure
- ❑ ❑ Blood in Sputum
- ❑ ❑ Cigarette Smoking
  - Daily # _____
  - Length _____
- ❑ ❑ Chest Pain
  - Type _____
- ❑ ❑ Asthma
- ❑ ❑ Environmental Toxin
  - Type _____
  - Length _____
- ❑ ❑ Calf Pain while walking
- ❑ ❑ Heart Disease
- ❑ ❑ Edema/Swelling
- ❑ ❑ Pneumonia/ Lung Infection
- ❑ ❑ Other

Eye/Ear/Nose/ Throat

- ❑ ❑ Pain in Eyes
- ❑ ❑ Visual Problems
- ❑ ❑ Difficulty Hearing/Deaf
- ❑ ❑ Ringing in Ears
- ❑ ❑ Discharge
- ❑ ❑ Nose Bleeds
- ❑ ❑ Change in Ability to smell
- ❑ ❑ Hoarseness
- ❑ ❑ Dental Problems
- ❑ ❑ Other _____
  _____

Females Only

- ·Menarche (1st Period)
  - Age _____ Year _____
- ·Flow
  - ❑ Scant ❑ Moderate
  - ❑ Light ❑ Heavy
- ·Regularity
  - # Days _____
  - Duration _____
- ❑ ❑ Abnormal/Painful Fluid Retention
- ❑ ❑ Premenstrual Syndrome
- ·Last PAP _____
- ·Menopause Onset _____
- ·# Pregnancies _____
- ❑ ❑ ·Difficult delivery

Notes: _____

_____

_____

· Please List any medications and/ or vitamins you currently take:

_____

_____

· Please *circle* those of which you have already had from the following:

(this list can affect your overall diagnosis, treatment plan, and possibly of being accepted for care)

- · Chicken Pox
- · Anemia
- · Small pox
- · Hepatitis
- · Tuberculosis
- · Polio
- · Rheumatic Fever
- · Pneumonia
- · Diphtheria

- **Medical History** (Please list any surgeries, hospitalizations, & car accidents)

_____
_____
_____
_____
_____
_____

- **Do you have any family history of Cancer, Heart Disease, Diabetes, Neurological Disorder (Parents, Siblings, Kids, Grand parents)?**

_____
_____

- **What is and how long have you worked at your current job?** _____

_____

- **Any work injuries at any job in the past? N Y,** _____
- **Any chance that you could be pregnant at this time? N Y**

_____ _____
Dr Signature Date

Notes

_____
_____
_____
_____
_____
_____
_____

Office Use Only:

ADJ: **POST:**

PT: **HOME:**

RTC:

Pt Name: _____ Date: _____

PRIVACY POLICY

POLICY STATEMENT

Core Health & Wellness Center (CH&WC) is committed to maintaining the privacy of your protected health information, which includes information about your medical condition and the care and treatment you receive from CH&WC and other health care providers. This notice details how your protected health information may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of CH&WC, and for other purposes permitted or required by law.

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following are examples of the types of uses and/or disclosures of our protected health information that may occur. These examples are **not** meant to include all possible types of use and/or disclosure.

1. **Care** – In order to provide care to you, CH&WC will provide your protected health information to those health care professionals directly involved in your care so that they may understand your medical condition, needs, and provide advice or treatment (e.g. your physician).
2. **Payment** – In order to get paid for some or all of the health care provided by CH&WC, your protected health information may be provided directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, CH&WC may need to provide your health insurance carrier with information about health care services that you received from CH&WC so that CH&WC can be properly reimbursed.
3. **Health Care Operations** – In order for CH&WC to operate in accordance with applicable law and insurance requirements and in order for CH&WC to provide quality and efficient care, it may be necessary for CH&WC to compile, use and/or disclose your protected health information. For example, CH&WC may use your protected health information in order to evaluate the performance of CH&WC's personnel in providing care to you.

WHEN WRITTEN AUTHORIZATION MAY NOT BE REQUIRED

1. **Personal Representative** – To such a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
2. **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury, or disability. This includes reports of child abuse or neglect.
3. **Abuse, Neglect, or Domestic Violence** – To a government authority if CH&WC believes that you have been the victim of abuse, neglect, or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
4. **Required by Law or Law Enforcement Purposes** – In certain instances, your protected health information may have to be disclosed to a law enforcement official for law enforcement purposes. If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.
5. **Avert a Threat to Health or Safety** – CH&WC may disclose your protected health information if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
6. **Workers' Compensation** –CH&WC may be required to disclose your protected health information to an individual or entity that is part of the Workers' Compensation system.

LIABILITY INSURANCE DISCLOSURE

1. As required by NRS 634.1295 CH&WC is required to inform you that Dr. Forsberg does not carry nor is covered by any liability insurance at this time.

Privacy Policy --- By signing I've acknowledged I've received or been offered the Privacy Practices for Core Health & Wellness Center.

_____ _____ _____
Print Name Signature Date

-or-

_____ _____ _____
Patient Representative Print Name Signature Date

SS# _____

DOB _____

❑ Decline, Reason _____

_____

Office Use Only

_____
Employee Signature

Date _____