New Patient Intake

Please completely fill out all applicable information

Date · ___________

Pt Name · _______________________, _____________________ _________
Last First Mid

DOB · _________________ SS# · ________________ Gender · M F

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)

Other complaints ·

_______________________________ (2)

_______________________________ (3)

(Fill out for Complaint 1)

· Have you had this before? N Y

· 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 · Trouble GOING or STAYING asleep?

· Is the pain worse in: AM PM All Day

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

(how) _______________________________

____

Visual Analog Pain Severity Scale

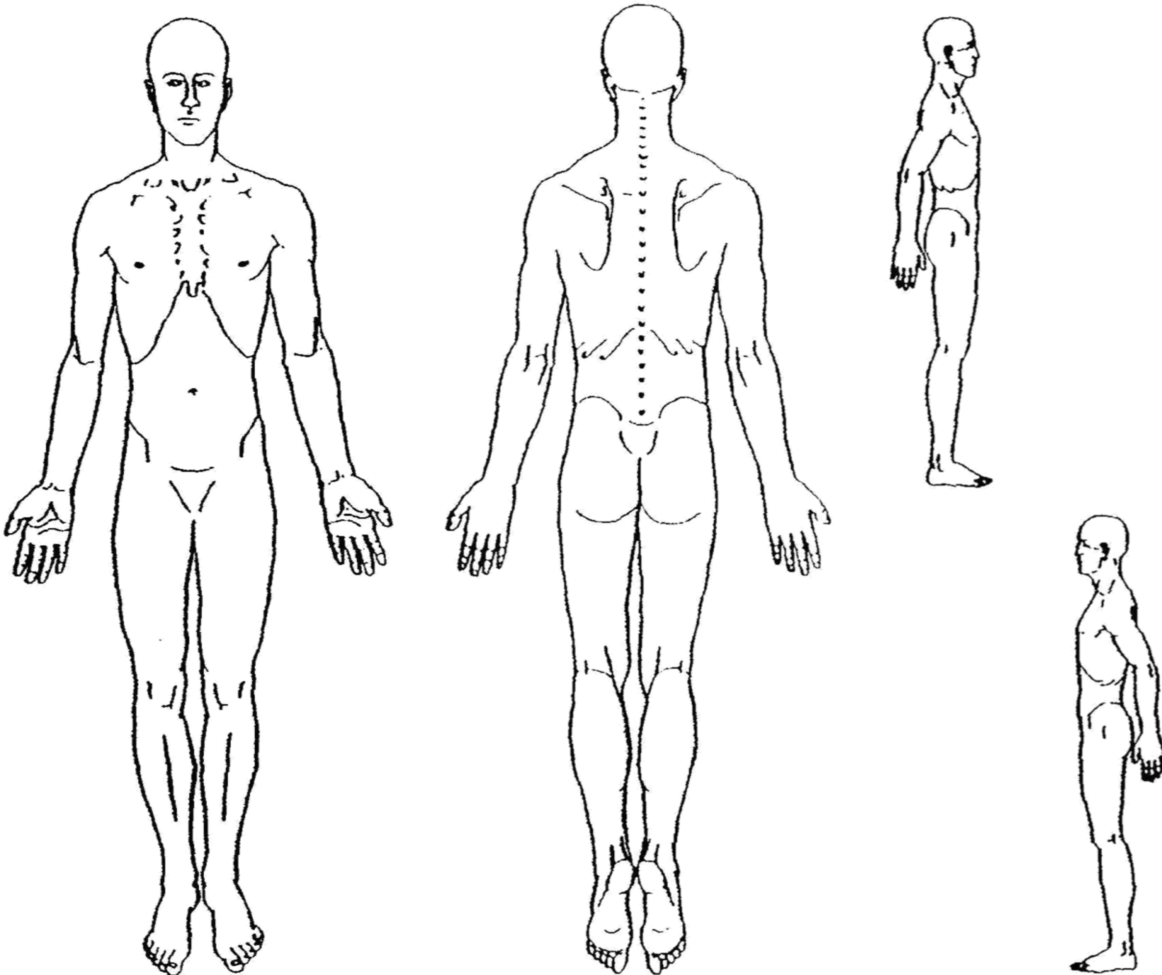
Instructions: please place a mark on the line that corresponds to how you presently feel.

NO PAIN ---1---2---3---4---5---6---7---8---9---10--- Worst Pain Ever

Pain Diagram

Using the key, on the diagram below 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
❑	❑	Neck Pain
❑	❑	MidBack Pain
❑	❑	Low Back Pain
❑	❑	Arm Pain
❑	❑	Leg Pain
❑	❑	Joint Pain/Stiffness
❑	❑	Fracture/Dislocation
❑	❑	Muscle Weakness
❑	❑	Trouble Swallowing

P	C	Nervous System
❑	❑	Numbness
❑	❑	Dizziness
❑	❑	Fainting
❑	❑	Loss of Balance
❑	❑	Seizures
❑	❑	Stroke
❑	❑	Depression
❑	❑	Paralyziz
❑	❑	Headaches

P	C	Gastro-Intestinal
❑	❑	Change in Appetite
❑	❑	Food Intolerance
❑	❑	Nausea/Vomiting
❑	❑	Heart Burn/GERD
❑	❑	Gas
❑	❑	Constipation
❑	❑	Gallbladder Issues
❑	❑	Abdominal Cramps
❑	❑	Ulcers
❑	❑	Diarrhea
❑	❑	Hemorrhoids
❑	❑	Liver Disease
❑	❑	Black/ Bloody Stools

P	C	Cardio/Respiratory
❑	❑	Shortness of Breath
❑	❑	Asthma
❑	❑	Cigarette Smoking
❑	❑	Daily # _______________
❑	❑	Length _______________
❑	❑	Chest Pain
❑	❑	High Blood Pressure
❑	❑	Blood in Sputum (cough)
❑	❑	Environmental Toxin
❑	❑	Type ________________
❑	❑	Length ______________
❑	❑	Calf Pain While Walking
❑	❑	Heart Disease
❑	❑	Edema/Swelling
❑	❑	Pneumonia/ Lung Infec
❑	❑	Other ____________________

P	C	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 ___________________
		Length _________________
❑	❑	Change in Sex Drive
❑	❑	Pain During Sex
❑	❑	Other _________________

P	C	Eye/Ear/Nose/Throat
❑	❑	Pain in Eyes
❑	❑	Visual Problems
❑	❑	Difficulty Hearing/ Deaf
❑	❑	Ringing in Ears
❑	❑	Discharge
❑	❑	Nose Bleeds
❑	❑	Change in ability to smell
❑	❑	Hoarsness
❑	❑	Dental Problems
		Other ____________________

P	C	Females Only
		Menarch (1st Period)
		Age ______ Year ________
		Flow
		❑ Scant ❑ Moderate
		❑ Light ❑ Heavy
		Regularity
		# Days ________________
		Duration ______________
❑	❑	Abnormal/Painful
		Fluid Retention
❑	❑	Premenstral Syndrome
		Last PAP _____________
		Menopause Onset ______
		# Pregnanies __________
❑	❑	Difficult Delivery
❑	❑	Polycystic Ovarian Syndrome
❑	❑	Endometriosis

Notes:____

____

____

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

____

____

· Please Tells us about the following:

Water Intake ____________________ Dietary Restrictions (e.g. Vegan, Vegetarian) ____

Coffee Intake ____________________ ______________________________

· Medical History

Surgeries____

Hospitalizations____

Car accidents____

· Have you seen any other doctors for this condition? N Y

(who, results) ____

·Family history of Cancer, Heart Disease, Diabetes, or Neurological Disorders (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

Pt Name: ____________

Date: ____________

______________________ Dr Signature ______________ Date

Notes

____

Office Use Only:

ADJ: **POST:**

PT: **HOME:**

RTC:

IDC-10:
1)
2)
3)
4)

PRIVACY POLICY (PP)

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 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 --- I acknowledge I've received or been offered the PP for CHWC

____________________ ____________________ __________
Print Name Signature Date

-or-

____________________ ____________________ __________
Patient Representative Print Name Signature Date

SS# ____________________

DOB ____________________

❑ Decline, Reason ____________________

____

Office Use Only

____
Employee Signature

Date __________