NEW PATIENT INTAKE FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION
PLEASE NOTE THAT ALL INFORMATION YOU PROVIDE WILL BE HELD IN STRICT CONFIDENCE AND WILL NOT BE DIVULGED TO OTHERS WITHOUT YOUR AUTHORIZATION

Today's Date_____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Social Security number: _____
Age: _____ Sex: M □ F □

ETHNICITY: Caucasian____African American/Black____Asian_____Hispanic____Other_____

Address: _____City: _____State_____ Zip: _____

Phone: (___) _____ E-Mail Address: _____

Occupation: _____ Employer: _____

Married_____ Single_____ Divorced_____ Widowed/Widower_____ Committed Relationship_____

Spouse's Name_____ Phone number: _____

Person to Notify in Case of Emergency_____ Primary Care Provider: _____

Phone: _____ Relationship: _____

Insurance Carrier: _____ Subscriber/Guarantor: _____

Group Number: _____ Member ID number: _____

Secondary Coverage: _____

PRESENT COMPLAINT(S)

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

In the space below, please describe the present complaint(s) which brought you to the OneCare Health- Advanced Practice Health & Wellness Corp., for care. After completing this first section, please complete the questionnaire on the following page. The information you provide concerning past and present symptoms, and diseases assists your provider in obtaining an early understanding of your state of health.

What is your most important reason for making this appointment with OneCare Health- Advanced Practice Health & Wellness, Corp.? _____

DID YOU GO TO THE HOSPITAL OR EMERGENCY ROOM FOR THIS CONDITION? □ NO If "NO" skip to the next section.
□ YES If "YES", please continue to fill out this section.

Name of Facility_____

Location: _____
Did you go to the hospital by: □ Ambulance □ Car □ Other: _____

Were x-rays/imaging taken? □No □ Yes If yes, of what body region(s)? _____

What was your diagnosis? _____

What treatment did you receive? _____

Did they recommend any follow-up treatment? □ No □Yes,

If yes, what? _____

When did your main problem begin (*a specific date if possible)?* _____

Briefly describe how your problem began:

_____
_____

What makes your problem BETTER?

□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity □ Nothing

□ Hot □ Cold □ Other _____

What makes your problem WORSE?

□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity □ Nothing

□ Hot □ Cold □ Other _____

How often are the complaints present?

□ Constant (76-100%) □ Frequent (51 – 75%) □ Occasional (26-50%) □ Intermittent (25% or less)

Since your problem began the pain has: □ Increased □ Decreased □ Not changed
What treatment have you received for this present condition?

□ No treatment (professional or self-treatment) □ Medication(s) (Rx and OTC): _____

□ Physical Therapy □ Chiropractic □ Acupuncture □ Injections □ Surgery □ Other: _____

Where and when did you last receive health care? _____

Please list any hospitalizations and surgeries you have undergone:

_____

Please list any serious trauma you have had, such as an accident or fall:
_____

Please list any foods, drugs or other substances to which you have allergic, anaphylactic or other adverse reactions. (Please specify if anything has caused you to have an anaphylactic reaction):
_____
_____

Please list all vitamins, minerals, amino acids, food supplements and herbs that you are currently taking: Please list all medications – prescription and over the counter, that you are currently taking:

_____
_____

Have you ever had an adverse reaction to an immunization? Y[ ] N[ ] If yes, which immunization:_____

Have you ever had an adverse reaction to any medication or recreational drug? Y [] N []

If yes, which? _____

Have you ever been exposed to: The AIDS virus (HIV), Tuberculosis (TB), Hepatitis virus (A, B or C)?
[ ] yes [ ] no

Do you have any concerns about AIDS, TB or hepatitis that you would like to discuss? [] yes []no

How did you hear about us? _____

Family Medical History: To the best of your knowledge, has your mother, father, siblings or grandparents ever had any of the following? [ ] Adopted/don't know

[ ] High cholesterol [ ] Anxiety/panic attacks [ ] Arthritis
[ ] Ulcerative colitis [ ] Alcoholism [ ] Obesity [] Osteoporosis
[ ] Eczema [ ] Stroke [ ] Autoimmune disease [ ] Cancer [ ] Mental illness [ ] Allergies [ ] Kidney disease
[ ] Depression [ ] Alzheimer's [ ] Diabetes [ ] Thyroid disease[ ] Asthma[ ] Heart disease/Hypertension [ ] Crohn's disease
[ ] Other serious illness (please list here): _____

How would you grade your overall stress level?

□ No stress □ Minimal stress □ Moderate stress □ Greatly stressed

Physical activity at work:

□ Sitting more than 50% of the workday □ Light manual labor □ Moderate manual labor □ Heavy manual labor

General physical activity

□ No regular exercise program □ Light exercise program □ Strenuous exercise program

IF IN PAIN NOW, PLEASE COMPLETE THE SECTION BELOW. IF NOT CURRENTLY IN PAIN, PLEASE SKIP TO THE NEXT PAGE.

I AM CURRENTLY IN PAIN [] yes []no

Please locate and mark the quality of your pain on the body outlines provided.

Please use the code letters as indicated below:

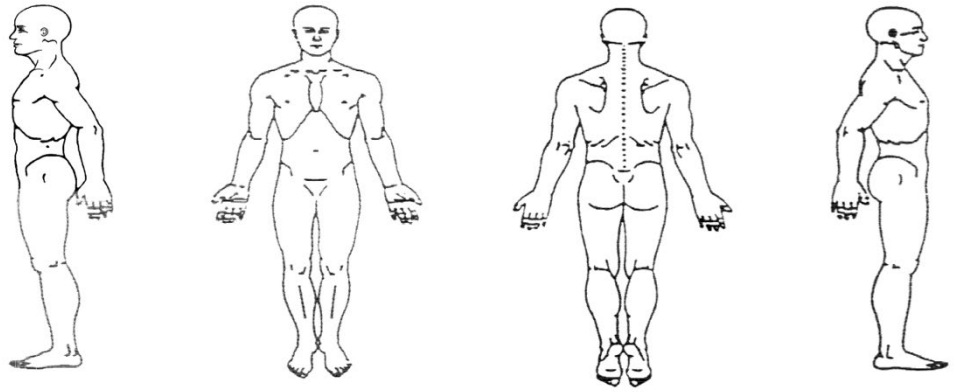
A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing X = Other

Please Mark Your Level of Pain Below:

No Pain ----------Worst Pain

1 2 3 4 5 6 7 8 9 10 (circle)

What percent of the time is your pain at this level? _____%



REVIEW OF SYSTEMS

*Please check all symptoms you have experienced in the last **6 MONTHS**. If your health care provider already knows about any condition below/and or the condition is the reason for today's visit, OK, to leave blank.*

Constitutional/General
- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain

_____

- ☐ Other:

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Wear Glasses

_____

- ☐ Other:

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Nasal Congestion/Sinus Issues
- ☐ Hearing Loss

_____

- ☐ Other:

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath

_____

- ☐ Other:

Endocrine
- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes

_____

- ☐ Other:

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Palpitations
- ☐ Varicose Veins

_____

- ☐ Other:

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion or Heartburn
- ☐ Blood in Stools
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties

_____

- ☐ Other:

Psychological
- ☐ Depression
- ☐ Anxiety

_____

- ☐ Other:

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising
- ☐ Bleeding Tendencies

_____

- ☐ Other:

Genitourinary
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating

_____

- ☐ Other:

Skin
- ☐ Skin Rash
- ☐ Itching
- ☐ Discoloration of the Skin
- ☐ Lumps or Masses

_____

- ☐ Other:

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking

_____

- ☐ Other:

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Convulsions/Seizure
- ☐ Other: _____

Notice to Pregnant Women: All female patients must inform the clinician if they know or suspect they are pregnant as some procedures and therapies described herein may present a risk to the pregnancy.