Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Billing Questionnaire

Patient Name: _____

DOB: _____

Address: _____ City_____

State: _____ Zip_____

Phone #: Home_____ Mobile_____

Email address: _____

Primary Care Physician Name: _____

Phone: _____ Fax: _____

Address: _____

Significant Other/Partner Name:

Emergency Contact Name (if not the same as above):

Emergency Contact Phone #:

Employer Name:

Insurance Info: BRING IN CARD TO PHOTOCOPY

Guarantor's Name:

Guarantor's DOB:

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Female History Questionnaire

Name: _____ Age: ____ Gender: M F

Occupation: _____

Referred by: _____

Primary Care Provider: _____

Other Practitioners (massage, chiropractor, acupuncturist, physicians)

_____

_____

_____

_____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Are you still menstruating? Y N

If not, when was your last period? _____

Do you take any hormones? Y N

If so, please list them: _____

If not, have you ever taken hormones? Including birth control pills, shots, or implants?

Y N

Which ones? _____

How many pregnancies have you had?

How many children did you have?

How many vaginal births? _____ or C-sections?_____

Have many miscarriages or abortions?

Have you had any female surgeries, other than C-section? Y N

What? When? _____

Did it fix the problem? _____

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Do you have any of the following? (circle all that apply)

Urine leakage	Weight gain/loss	Trouble sleeping
Low desire to have sex	Brain Fog	Low Energy
Trouble with orgasm	Hair Loss	Brittle nails
Pain with sex	Temperature Intolerances	Hot Flashes
Vaginal Dryness	Heavy Period/Cramps	Bleeding Gums

Allergies/Sensitivities

_____ _____

_____ _____

_____ _____

Past Surgery, Hospitalizations and/or Accidents

Date	Surgeries/Medical Issue
_____	_____
_____	_____
_____	_____
_____	_____

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Past Medical History & Family History

	Self	Mother	Father	Siblings	Grand-parents	Children
Alcoholism						
Alzheimer						
Arthritis						
Asthma/Lung Issues						
Bleeding Disorder						
Cancer(s)						
Depression/ Anxiety						
Diabetes						
Drug Abuse						
Epilepsy						
Glaucoma/Eye problems						
Heart Disease: (attack,palpitations)						
High Cholesterol						
High Blood Pressure						
Intestinal Issues: IBS, stomach						
Kidney Disease						
Liver Disease: Hepatitis						
Migraines						
Thyroid Issues						
OTHER:						

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Medications & Supplements

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social

Do you drink Alcohol? Y N How much? _____

Do you use Tobacco? Y N How much? _____

If you did in the past, when did you quit? _____

Do you follow a special Diet? Y N What type? _____

Do you exercise regularly? Y N How much? _____

Do you have any other Hobbies? Y N

What are they?

_____

_____

How tall are you? _____ How much do you weigh? _____

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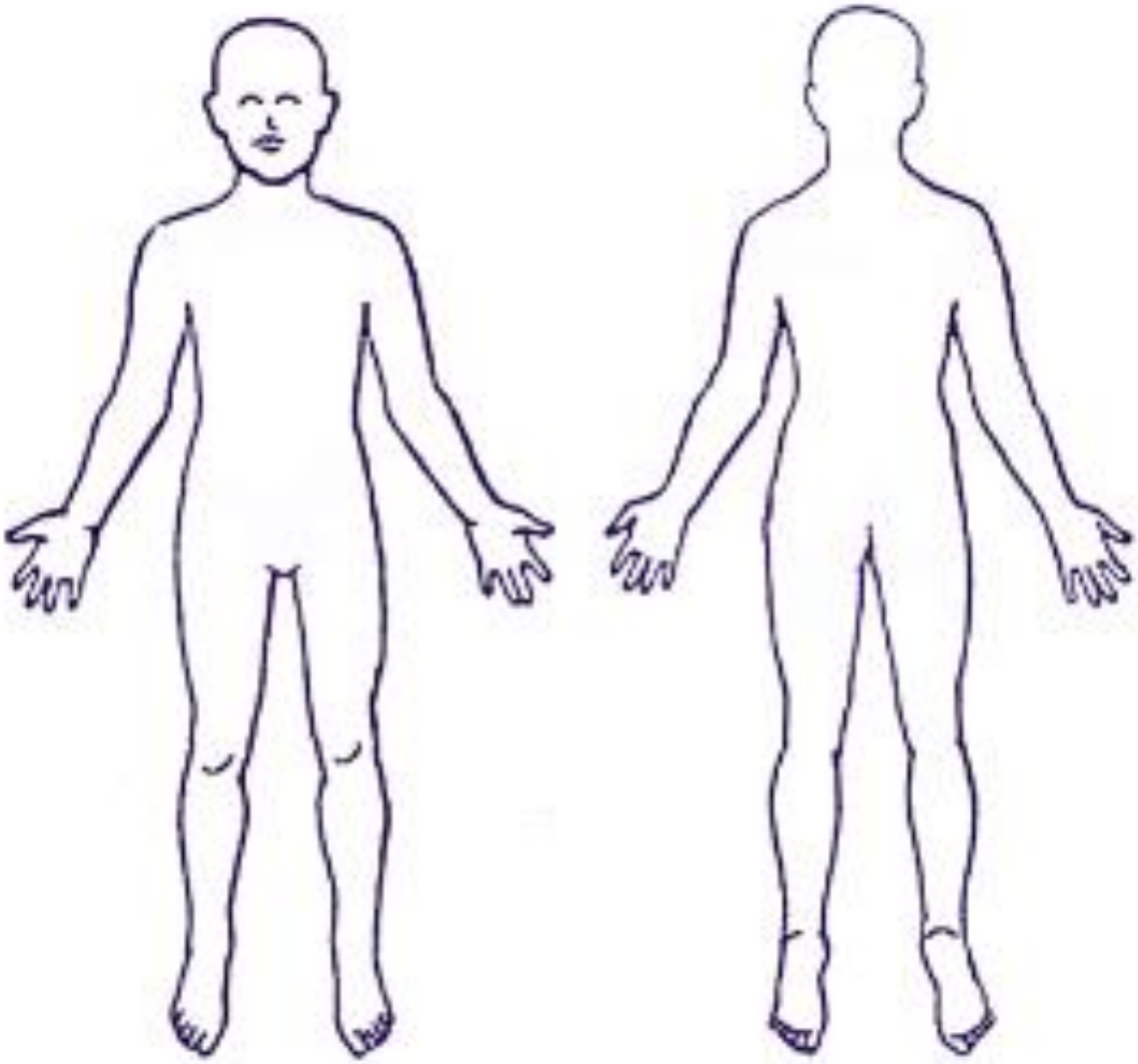

PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

PAIN with an X, DISCOMFORT with ////, and RADIATION of the pain or discomfort with #

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SELECT THE ONE WORD IN EACH CATEGORY (1-10) THAT BEST DESCRIBES YOU:

1. ____ DETERMINED	____ **CONVINCING**	____ **PREDICTABLE**	___ **CAUTIOUS**
2. ____ STRONG WILLED	____ PERSUASIVE	____ EASY-GOING	___ ORDERLY
3. ____ DIRECT	____ EXPRESSIVE	____ KIND	____ ANALYTICAL
4. ____ BOLD	____ SOCIABLE	____ COOPERATIVE	____ PRECISE
5. ____ OUTSPOKEN	____ ANIMATED	____ PATIENT	____ LOGICAL
6. ____ DECISIVE	____ TALKATIVE	____ LOYAL	____ CONTROLLED
7. ____ DARING	____ OUT-GOING	____ AGREEABLE	____ CAREFUL
8. ____ RESTLESS	____ ENTHUSIASTIC	____ CONSIDERATE	____ THOROUGH
9. ____ COMPETITIVE	____ INSPIRING	____ CONSISTENT	____ DETAILED
10. ____ AGGRESSIVE	____ PLAYFUL	____ SATISFIED	____ ACCURATE