Medical and Wellness Center

Patient Intake Form

Patient Name_____ Date: _____
Email: _____
SS #/SIN_____ DOB_____ □ Male □ Female
Home phone_____ Cell Phone _____
Check appropriate Box **:** □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated
Patient's Address _____ City _____ State_____
Zip_____
Employer Name: _____ Spouse or guardian's name: _____
Spouse's Employer_____ Whom may we thank for referring you? _____
Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

Responsible Party
Name of the person responsible for this account: _____ Relationship to patient: _____
Address_____ Home Phone_____
E-Mail_____ Cell Phone _____
Driver's License # _____ Date of Birth: _____ Is the person currently a patient at our office? Yes No
Do you have any Medical insurance? ☐□ Yes □ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone
_____
Address of Employer_____ State _____
Zip_____ Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____
Zip_____

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have),

I am ultimately responsible to pay 180 Health Medical and Wellness Center as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/ healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/ insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a

result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name

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Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____
History of Present illness:

Location of problem:
_____

(Where is the pain/problem?)

Severity:
_____

How severe is the pain/problem on a scale of 1-10 with 10 being the most severe? List your range of pain. When is it at its worst and best?

Timing: _____

(Does the pain/problem occur at a specific time?)

What other areas of your body are affected by this problem?

_____
_
_____
_
(Ex: ankle problems due to knee problems ...)

What have you tried in the past to handle your problem?
:

_____
__ (Heat, ice, over the counter medications, prescription medications, rest, exercise, physical therapy, chiropractic adjustments, massage)

Duration:
_____

(How long have you had this pain/ problem? When did it start?)

What activities have you given up or changed due to this problem?:
_____
(Example: stopped climbing steps as often)

What activities increase symptoms/makes problems worse?:
_____

(What makes the pain/problem worse or better? Going up and
down stairs, brushing hair, etc)

Are you on any medications now for this problem?_____

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Past Medical History
(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)
Measles…… NO YES Anemia……...NO YES Back Trouble……NO YES
Hepatitis…….. NO YES
Mumps…….. NO YES Bladder Infection…….NO YES High Blood Pressure……NO YES
Ulcer……NO YES
Chicken Pox…… NO YES Epilepsy……NO YES Low Blood Pressure…….NO YES
Kidney Disease……NO YES
Whooping Cough… NO YES Migraine Headaches. NO YES Hemorrhoids……..NO YES

Thyroid Disease……NO YES
Scarlet Fever……. NO YES Tuberculosis……..NO YES Date of Last Chest X-Ray_____
Bleeding Tendency…….NO YES
Diphtheria…….. NO YES Diabetes……..NO YES Asthma……..NO YES
Any Other Disease…….NO YES
Small pox…….. NO YES Cancer…… .NO YES Hives of Eczema……...NO YES

Pneumonia…….. NO YES Polio…….. NO YES AIDS & HIV……NO YES
Rheumatic Fever… NO YES Glaucoma……NO YES Infectious Mono……NO YES
_____
Arthritis…….. NO YES Hernia……NO YES Bronchitis……..NO YES
Venereal Disease… NO YES Blood or Plasma Mitral Valve Prolapse….NO YES _____
Transfusion……..NO YES Stroke……NO YES

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication: (include non-prescription)

_____
_____

Primary Care Physician: _____

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____
Do you have a sulfa allergy? NO YES

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Allergies/Medication Allergies:

_____

_____

CLINICIAN SIGNATURE: _____

DATE REVIEWED:_____ Name:_____

DOB _____ Date:_____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse:			
Children:			

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Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Muscular/Skeletal		**Neurological:**		**General:**	
Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Tingling in hands or feet	1 2 3 4 5	Irritability	1 2 3 4 5
Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5	Burning in hands or feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Hypersensitivity	1 2 3 4 5	Feeling foggy	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Difficulty with Balance	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Hip Pain	1 2 3 4 5				
Knee Pain	1 2 3 4 5				
Ankle/Foot Pain	1 2 3 4 5				
Pain b/t shoulder blades	1 2 3 4 5				

Do you have a Living will?.....NO YES Do you have a DNR? (DO NOT RESUSCITATE).....NO YES

IF YES PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____
Signature of person holding POA for patient

Date

_____ _____ _____
Doctor's Review Signature of Doctor Date