Infinite Healing Center

New Patient Questionnaire

Today's Date [/ /]

First Name______________________________ **Last Name**_____________________________________

Address 1____

Address 2____

City_____________________________________ **State**____________ **Zip Code**____________________

Contact Preference *(please check one)*

❐**Home Phone**____________________________ ❐**Mobile Phone**______________________________

Cell carrier if you would like to receive a text for confirmation calls:_____________________________

E-Mail Address:____

Date of Birth:_____/_____/_____ **Age:**_______ **Gender**:❐ Male ❐ Female SSN:___________________

Marital Status (*please check one*) ❐Single ❐Married ❐Divorced ❐Widowed ❐Other________________

Employment Status *(please check one)* ❐Employed ❐FT Student ❐PT Student ❐Other ❐Retired ❐ Self

Race *(please check one)* ❐White ❐Hispanic ❐African American ❐Asian ❐Other______________________

Ethnicity *(please check one)* ❐Hispanic or Latino ❐Not Hispanic or Latino ❐ I choose not to specify

Preferred Language (*please check one*) ❐English ❐Spanish ❐Other________________________________

Tobacco Use (*please check one*) ❐ Current Smoker ❐Former Smoker ❐Never Smoked

If yes, how long have you smoked? ______________________ **How Much?** ________________________

Whom may we thank for referring you to us? ____

Family Physician____

Pharmacy *(location & phone)* ____

Verification Question *(please select one)*

❐ What is the name of your favorite pet? ____

❐ What is your favorite color? ____

❐ What is your mother's maiden name? ____

❐ What city where you born in? ____

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Patient Name ____Age:_________

Symptoms: **Mark the areas of your pain on the figure below using the following symbols:**

Aching XXX	**Numbness OOO**	**Pins/Needles *** **	**Stabbing ////**	**Burning +++**	**Tingling ^^^**

List your symptoms and rate its pain level below

Symptom #1.____________________

|____________________|____________________|

Mild **Severe**

Symptom #2.________________________

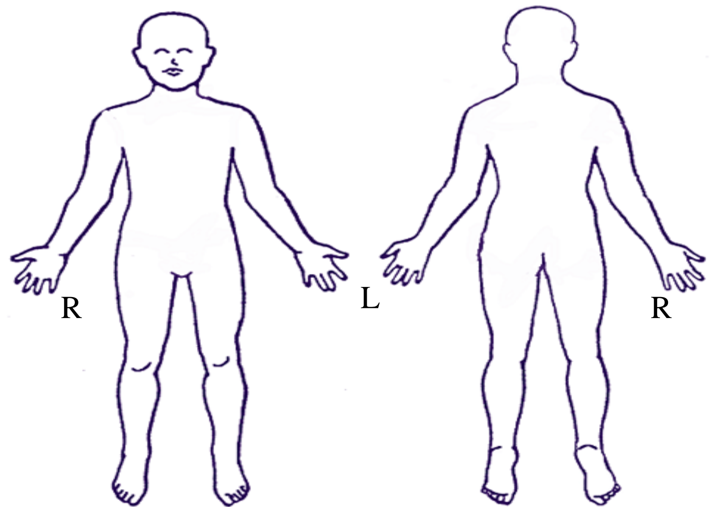
|____________________|____________________|

Mild **Severe**

Symptom #3.____________________

|____________________|_______________________|

Mild **Severe**



Overall **pain level** *(circle one)* ***1 2 3 4 5 6 7 8 9 10***

What is your occupation? _________________________

Is this a New ❒ or Old ❒ condition? How long have you had this condition?___________________

What is the *CAUSE* of your condition? Describe the onset.

____

Do you experience any weakness? YES NO

Is this condition the Same ❒ Improved ❒ or Worse ❒ ?

What makes if feel better? ___________________ What makes it feel worse?______________________

Have you had injections for pain in the past? Yes No

Epidural_______ Trigger point_______ Other_______

Have you seen other specialists for this pain? Yes No If so, Who?_____________________________

Have you had an MRI, CT or other tests for this pain?____

Females ONLY: **Are you pregnant, or is there a possibility that you are pregnant? YES NO**

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Date of the first day of your last menses? ___________________ Your initials here: ______

List *ALL* surgical history____

____

List *ALL* hospitalization history____

____

List *ALL* accidents & injuries ____

____

Current Medication with dosage

If NO current medications, check here ❒

1) _________________________________ **5)** ___________________________________

2) _________________________________ **6)** ___________________________________

3) _________________________________ **7)** ___________________________________

4) _________________________________ **8)** ___________________________________

Allergies, if NO allergies check here ❒

1) _________________________________ **3)** ___________________________________

2) _________________________________ **4)** ___________________________________

Medical History *(Check only ones that you HAVE or have HAD in the past)*

❒Heart disease/ Heart attack
❒High blood pressure
❒Asthma
❒Bronchitis/ Emphysema
❒Stomach ulcers
❒Hepatitis/HIV/AIDS
❒Kidney infection
❒Kidney stones
❒Prostatic problems
❒Change in ability to pass urine
❒Difficult bowel movement
❒Urine incontinence
❒Bowel incontinence
❒Diabetes
❒Thyroid disease
❒Cancer____________

❒ Rheumatic disease
❒Arthritis
❒Swelling in toe or finger joints
❒Neck Pain
❒Shoulder problems
❒Pain between the shoulder blades
❒Upper extremity problems
❒Leg problems
❒Painful joint(s)
❒Stiff joint(s)
❒Walking problems
❒Seizure disorder
❒Broken bones
❒Difficulty swallowing
❒Tuberculosis
❒Other_____________

❒Dizziness
❒Loss of consciousness
❒Fainting
❒Headaches
❒Difficulty concentrating
❒Difficulty with memory
❒Insomnia
❒Difficulty falling asleep
❒Feeling tired in morning
❒Unexplained weight loss
❒Night sweats
❒Fever
❒Stroke
❒Varicose veins
❒Blood clots
❒Other______________

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Family History

Grandfather Major Illness______________________________ Cause/ age of death_______ Deceased ❒
Grandmother Major Illness______________________________ Cause/ age of death_______ Deceased ❒
Mother Major Illness___________________________________ Cause/ age of death_______ Deceased ❒
Father Major Illness___________________________________ Cause/ age of death_______ Deceased ❒
Sibling Major Illness__________________________________ Cause/ age of death_______ Deceased ❒
Sibling Major Illness__________________________________ Cause/ age of death_______ Deceased ❒
Sibling Major Illness__________________________________ Cause/ age of death_______ Deceased ❒

(Clinical use only)

Height______'________" **Weight_________________** **BP_______/________**

Temp_________________ **Pulse___________________** **SA02__________%_**

Emergency contact information

Name:____ Phone number:________________________________
Name:____ Phone number:________________________________

<u>Patient Assignment and Release</u>

I, the undersigned, have insurance coverage with ____________________________________ and assign
(*Name of insurance company)*
___________________ and Infinite Health and Wellness all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

____
(Signature of insured or guardian)

____
(Date)