NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient File #: _____ **Today's Date: _____/_____/_____**

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*)_____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: _____/_____/_____ Age: ____ Marital Status (*Circle*): Divorced Married Single Separated Widowed
Gender (*Circle*): Male / Female Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
Social Security #: _____-_____-_____ Email Address: _____@_____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? □ **Yes** □ **No**

Employer /Employment Status □Employed □Unemployed □Full Time / □Part Time Student □Other
Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____) _____-_____ Type of Work: _____
Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information
Name: (*First*)_____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?
□ Yes □ No
Who besides yourself is responsible for your bill? □Self-Pay □Health Insurance
□Medicare □Medicaid □ Worker's Comp
□Auto Insurance □ Other (*Be Specific*): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____/_____/_____
Insured Person's Social Security #: _____-_____-_____
Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT:

_____
When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At its worst ____ At the present time _____ At least severe _____
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____
_____

SECOND COMPLAINT:

_____
When did it start? _____
Describe the condition:_____
What do you think caused the problem?_____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
_____
List past treatment for this condition and if they helped _____
_____

THIRD COMPLAINT:

_____
When did it start? _____
Describe the condition:_____
What do you think caused the problem?_____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
_____
List past treatment for this condition and if they helped _____
_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____
_____
_____
_____
_____
_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____
_____
_____
_____
_____
_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor.

_____
_____
_____
_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to True Wellness Integrated Medicine for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information
gathering so that the doctor can determine whether to accept me as a patient.

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
DATE