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? ____

Infinite Healing Center

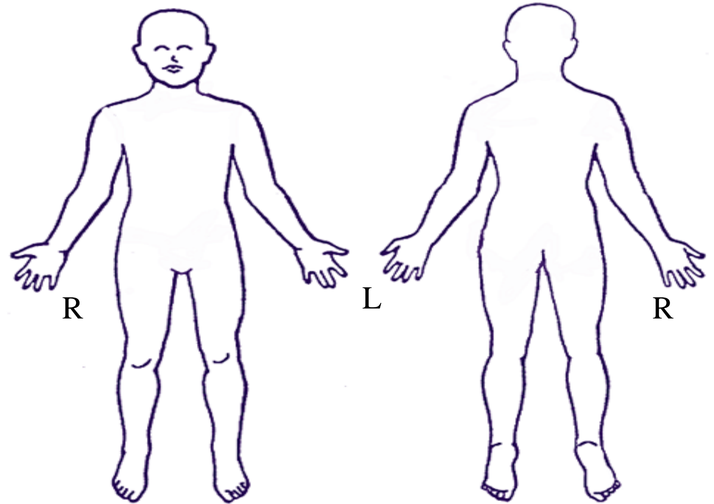
New Patient Questionnaire

IS THIS CONDITION DUE TO A MOTOR VEHICLE ACCIDENT? YES NO

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

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

<u>List your symptoms and rate its pain level below</u>



Symptom #1.___________________

|___________________|____________________|

Mild Severe

Symptom #2.______________________

|___________________|____________________|

Mild Severe

Symptom #3.___________________

|___________________|_____________________|

Mild Severe

<u>Overall</u> 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?___________________

Is this condition due to a motor vehicle accident? YES NO

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?____

Infinite Healing Center

New Patient Questionnaire

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

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

❐Muscle/Joint Pain
❐Itchy/Watery Eyes
❐Frequent Colds/Flu
❐Facial Swelling

❐Fatigue
❐Chronic Cough
❐Asthma
❐Difficulty Breathing

❐Congestion
❐Hives
❐Abdominal pain, diarrhea
❐Bloating

❐Headaches
❐Difficulty with memory
❐Night sweats
❐Feeling tired in morning
❐Night sweats/Hot Flashes
❐Thyroid disease

❐Fatigue
❐Insomnia
❐Rheumatic disease
❐Decreased Desire/Libido
❐Cold all the time
❐Mood changes

❐Difficulty concentrating
❐Difficulty falling asleep
❐Dizziness
❐Weight Gain
❐Irritability\Mood Changes
❐

❐High blood pressure
❐Heart disease/ Heart Attack
❐Bronchitis/ Emphysema
❐Stomach ulcers
❐Hepatitis/HIV/AIDS
❐Upper extremity problems
❐Kidney stones
❐Prostatic problems
❐Change in ability to pass urine
❐Tuberculosis
❐Cancer___________

❐Arthritis
❐Swelling in toe or finger joints
❐Neck Pain
❐Shoulder problems
❐Pain between the shoulder blades
❐ Leg problems
❐Stroke
❐Varicose veins
❐Stiff joint(s)
❐Difficulty swallowing
❐Other___________________

❐Loss of consciousness
❐Fainting
❐Unexplained weight loss
❐Difficult bowel movement
❐Walking problems
❐Seizure disorder
❐Anxiety
❐Broken bones
❐ Diabetes
❐Itchy/dry skin

Infinite Healing Center

New Patient Questionnaire

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)*