Name:_____ Date:_____

Welcome to our office. We will strive to provide you with the best possible care. To help us meet your healthcare needs; please fill out this form completely in ink. If you need assistance, please let us know.

Patient Registration

_____
Patient's Last Name

_____
Patient's First Name Middle Initial

_____
Address or PO Box Apt #

_____
City, State, Zip Code

_____ _____
Home Phone Cell Phone

_____
Email address

_____ _____
Date of Birth Social Security Number

Sex (Please circle)
Male Female

Marital Status (Please circle)
Married Single
Divorced Widowed

_____ _____ _____
Language Race Ethnicity

_____
Driver's License Number State

_____
Name of Employer Phone #

_____
Name of Emergency Contact Phone #

_____

PHARMACY INFORMATION

_____
Pharmacy Name Phone #

I understand and agree that I will be responsible for Any and all services rendered by Hope Alive Center And authorize the release of any diagnosis or records Of treatment to my insurance(s), Medicare/Medigap, To make payment directly to Hope Alive Center for services rendered. I certify that the information above is true and correct. Should my account be forwarded to an outside collection agency, I agree to pay all collection fees/attorney fees incurred.

Referring Physician (if applicable)

_____

Spouse/Parent (Please circle)

_____
Name

_____
Address or PO Box Apt #

_____
City, State, Zip Code

_____
Phone number (area code)

INSURANCE INFORMATION

_____
Guarantor (Person responsible for bill)

Primary Insurance

_____
Name of Primary Insurance Carrier

_____ **Related:** Self
Subscriber Name Spouse Child

_____ M F _____
Subscriber SS# Sex Date of Birth

_____
Subscriber Employer

_____
ID Number Group Number

Secondary Insurance

_____
Name of Secondary Insurance

_____ **Related:** Self
Subscriber Name Spouse Child

_____ M F _____
Subscriber SS# Sex Date of Birth

_____
Subscriber Employer

_____
ID Number Group Number

_____
Signature Date

Name:_____ Date:_____

PATIENT QUESTIONNAIR, PAGE 1 OF 4

_____ _____
Date Age
Martial Status: M S D W
_____
Name
_____
Occupation

Please indicate by circling, if you have suffered any of the following:

Asthma Arthritis Bladder Infections Diabetes Epilepsy Jaundice Gout

Goiter Glaucoma Hay Fever Heart Attack Heart Murmur Hernia

High Blood Pressure Rheumatic Fever Stroke Tuberculosis Ulcer

Cancer Psychiatric Disorder

Other medical problems NOT noted above:

_____
_____

List any hospitalization for illness, trauma, or surgery below, please give reason and dates of hospitalizations:

Date:	Reason for Hospitalization:

Medications: Please list ALL medications including over the counter medications, antacids, laxatives, birth control pills, vitamins, herbal supplements, etc.

Drug	Dose	How many times per day?	Length of time taken

NAME DATE

Name:_____ Date:_____

PATIENT QUESTIONNAIRE PAGE 2 OF 4

Allergies: Are you allergic to any medications, latex, or foods? If so, please list them and the problem that you experienced.

Medication/Food Allergy	Problem Experienced

Vaccinations within the past ten years (please include date it was given):

Tetanus (TT, Td, or DPT): _____MMR:_____
Pneumovax:_____Hepatitis B:_____
Influenza:_____HIB:_____

Health Maintenance Date (include dates, if known):

PPD (for TB):_____Flexible Sig/Colonoscopy:_____
Hemoccult:_____ Pap Smear/PSA:_____
Mammography:_____ Breast/Testes:_____
Stress Test:_____ EKG:_____
Chest X-ray:_____Echocardiogram:_____

Personal Health Habits:

Do you smoke?	Y	N	How many years? _____
Have you ever smoked?	Y	N	How many years?____How many packs?_____
Do you drink alcohol?	Y	N	How many drinks per week?_____
			Date of last drink_____
Do you exercise regularly?	Y	N	What kind of exercise?_____
			How often?_____
Do you use recreational drugs?	Y	N	How often?_____
			What kind?_____
			_____
Do you have trouble sleeping?	Y	N	How many hours nightly?_____
Do you follow a special diet?	Y	N	What kind?_____
Have you been exposed to toxins or fumes at work/home?	Y	N	What kind?_____

Name:_____ Date:_____

PATIENT QUESTIONNAIRE PAGE 3 OF 4

Review of Symptoms:

Have you had any of the following? If so, which one and when did they start?

General:			**When/explain**
Skin/rash?	Y	N	_____
Bruise easily?	Y	N	_____
Joints ever painful?	Y	N	_____
Lost or gained weight?	Y	N	_____
Sensitive to heat/cold?	Y	N	_____
Head and Neck:			
Frequent headaches?	Y	N	_____
Frequent colds?	Y	N	_____
Problems with vision?	Y	N	_____
Hearing?	Y	N	_____
Frequent nosebleeds?	Y	N	_____
Hair loss?	Y	N	_____
Difficulty seeing at night?	Y	N	_____
Taste alteration?	Y	N	_____
Bleeding gums?	Y	N	_____
Dry mouth?	Y	N	_____
Sores in mouth?	Y	N	_____
Chest and Cardiovascular			
Shortness of breath?	Y	N	_____
Wheezing?	Y	N	_____
Chest discomfort?	Y	N	_____
Extremities cold/numb?	Y	N	_____
Swelling of hands/feet?	Y	N	_____
Frequent coughing?	Y	N	_____
Coughing up blood?	Y	N	_____
Daytime drowsiness?	Y	N	_____
Loud snoring?	Y	N	_____
Unrested after sleep	Y	N	_____
Gastrointestinal			
Stomach pains?	Y	N	_____
Frequent nausea?	Y	N	_____

Name:_____ Date:_____

Frequent constipation?	Y	N	_____
Black stools?	Y	N	_____
Blood or pus in stool?	Y	N	_____
Vomiting blood?	Y	N	_____
Frequent diarrhea?	Y	N	_____
Trouble digesting food?	Y	N	_____
Frequent laxative use?	Y	N	_____

Genitourinary

Urinate>1 time/night	Y	N	_____
Urinate<6 times/day	Y	N	_____
Burning during urination	Y	N	_____
Urine brown or bloody	Y	N	_____
Sexual difficulties	Y	N	_____

Musculoskeletal

Knee problems	Y	N	_____
Back problems	Y	N	_____
Leg cramps	Y	N	_____
Joint pain	Y	N	_____
Change in mobility	Y	N	_____

Neurological

Dizziness	Y	N	_____
Memory loss	Y	N	_____
Tremors	Y	N	_____
Seizures	Y	N	_____
Headaches/Migraines	Y	N	_____

Reproductive History – Women Only

At what age did you first menstruate?	_____
When was your last menstrual period?	_____
Number of live births?	_____
Number of miscarriages or stillbirths?	_____
Number of abortions?	_____
Do you take oral contraceptives or have an IUD?	_____
Do you have a problem with vaginal discharge?	_____
Do you do self breast examinations?	_____
Do you have trouble holding your urine when you sneeze/cough?	_____

Name:_____ Date:_____

Men Only

Have you ever had prostate trouble?	Y	N
Has your urine stream become weak or slow?	Y	N
Do you have any children?	Y	N
Have you had pain, swelling, or lumps in your testicles?	Y	N

Family History

	Father	Mother	Sibling	Children
Asthma				
Heart Disease				
Hypertension				
Rheumatic Fever				
Stroke				
Cancer				
Obesity				

Mental Illness				
Liver Disease				
Arthritis				
Sleep Apnea				
High Cholesterol				
Bleeding Disorder				
Epilepsy				

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(to be completed by patient)

Use the opposite side of the page as necessary to complete your answers. Please print legibly.

(Circle one) Married Single Long-term relationship Divorced/Separated Widowed

Years married/long-term relationship _____ Times married _____ Times divorced _____

Children? [ ] Y [ ] N How Many? _____ List current ages _____

How many residing with you? _____ Do you have extended family nearby? [ ] Y [ ] N

Are you a caregiver for a family member? [ ] N [ ] Y Who, why and for how long? _____

Do they live with you? [ ] N [ ] Y

Education (most recent degree attainted)

[ ] Graduate school [ ] Undergraduate [ ] Professional or Vocational school

[ ] High School [ ] GED [ ] No degree

Name:_____ Date:_____

Employment

Are you current employed [ ] Y Where? _____
[ ] N (If "no", where were you employed last? _____
What type of work did/do you do? _____
How long have/did you work(ed) there? ____ Are you on disability? [ ] Y [ ] N For how long?____
Please explain why are you on disability? _____

Criminal History

Have you ever been arrested? [ ] N [ ] Y DWI/DUI Drug-related Domestic Violence
Other, please explain_____

Mental Health/Treatment

Have you ever been abused? [ ] N [ ] Y Physically Sexually (including rape/attempted rape)
Verbally Emotionally
Have you ever attended:
AA Current [ ] In the past [ ] NA Current [ ] In the past [ ] Celebrate Recovery Current [ ]
In the past [ ] Other support group, please name and if currently attending _____
If you are currently attending meetings, what factors led you to stay? _____
_____

Please list any time spent in detox or rehabilitation facility:
Name of facility and dates attended:

_____
_____
_____
_____
_____
_____
_____

Have you ever been in counseling or therapy? [ ] N [ ] Y Are you currently in counseling or therapy? [ ] N [ ] Y Name of counselor or therapy _____
For how long? _____ For what reason? _____
Has it been helpful? [ ] N [ ] Y How so? _____
_____

Have you ever been treated as on outpatient for using substances? [ ] N [ ] Y Please describe when, where, and for how long?

_____
_____
_____
_____

Name:_____ Date:_____

How long have you been using substances? _____

Substance Use History

	No	Yes/Past or Yes/Now	How administered	How much	How often	Date/Time of last use	Quantity last used
Alcohol							
Caffeine pills or drink							
Cocaine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Opiates							
PCP							
Stimulants							
Tranquilizers							
Ecstasy							
Other							
Other							

Did you ever stop using any of the above because of dependence? [ ] N [ ] Y Please list

_____

_____

What was your longest period of abstinence? Please explain _____

_____

MD NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____