Healing Hands Wellness Center

New Patient Form

Patient Information

Full Name (First, Middle Initial & Last) ____________________

Date of Birth ____________ Social Security # ____________ Male or Female (check one)

Street Address ____________________

City ____________ State ______ Zip ______ Email ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Marital Status S M D W Spouse's name ____________ Ref by ____________

Insured Information If you are the insured mark this box and skip to Insurance Information section

Full Name (First, Middle Initial & Last) ____________________

Relationship to patient ____________ Date of Birth ____________ SS # ____________

Street Address ____________________

City ____________ State ______ Zip ______ Email ____________

Home Phone ____________ Alternate Phone ____________

Insurance Information If you have a secondary insurance, please list the same information as below on the back of this form.

Insurance Carrier ____________________

Policy Number ____________ Group Number ____________

Street Address ____________________

City ____________ State ______ Zip ______ Phone ____________

Employer Information

Current Employer ____________ Position ____________

Are you, or do you think you may be pregnant? YES NO Cause of Current Complaint: Auto Accident Work Injury Other

Do you currently have an auto accident or worker's compensation case pending? YES NO

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my cure and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature ____________________ Date ____________

Financial Responsibility/Waiver

We can bill your health insurance company as a convenience to you. You are responsible for knowing about your insurance coverage prior to your appointment. You are responsible for obtaining any necessary authorizations prior to your appointment. You will be responsible for your entire bill if you do not have the required authorization. If your visits are not covered by your insurance plan, you will be responsible for the entire bill. Co-payments and/or deductibles are due at the time of your visit.

I have read and understand my financial responsibility to Healing Hands Wellness Center and hereby affix my signature as an acknowledgement of this understanding.

Responsible Party's Signature ____________________ Date ____________

Name of Responsible Party ____________________ Witness ____________________

Healing Hands Wellness Center

Patient Health History

Patient: ______________________________ **Date:** ____________________

SOCIAL HISTORY:

Are you? Single Married Divorced Widowed Number of children: ____________

Do you exercise? Yes No
If yes, how often? Occasionally 1-2 times a week 3-4 times a week Daily

Do you eat a balanced diet? Yes No

Do you get enough rest? Yes No

Do you drink alcoholic beverages? Yes No
If yes, how often? Occasionally 1-2 times a day 3-4 times a day More frequently

Do you drink caffeinated beverages? Yes No
If yes, how often? Occasionally 1-2 times a day 3-4 times a day More frequently

Do you smoke? Yes No

If yes, how often? Occasionally Less than 1 pack a day 1-2 packs per day More than 2 packs per day

MEDICAL HISTORY:

Childhood illnesses: Mumps Diabetes Cancer Asthma Rheumatic Fever
Please list any serious childhood illnesses or problems not marked above:

______________________________ Age: __________
______________________________ Age: __________
______________________________ Age: __________

Hospitalizations or Surgeries, please list reason and approximate date:

______________________________ Date: __________
______________________________ Date: __________
______________________________ Date: __________

Adult Illnesses or Injuries, please list anything not listed above, including any major falls, work injuries, auto or other types of accidents:

______________________________ Date: __________
______________________________ Date: __________
______________________________ Date: __________

Medications, Vitamins, or Supplements, including Home Remedies, please list all that you have taken in the last six months:

____
____
____

Please list any medications, vitamins or herbs you are allergic to: ______________________________

____

Any other allergies: ______________________________

____

FAMILY HEALTH HISTORY:

Mother: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died ________

Father: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died ________

Siblings: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died ________

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Patient Symptoms Complaints

Patient:____ Date of Visit:____________________

IMPORTANT: Check all present symptoms. Underline recent past symptoms. Sign below. Be complete

Muscle, Ligament & Joint

Neck: Weakness - Pain – Stiffness – Swelling – Spasms – Disc – Limited Movement – Pain on Motion – Surgery – Throat Muscles Swollen or Sore.
Worse: After Sleeping – During Day – End of Day.

Mid Back: Weakness – Pain – Soreness. Worse: After sleeping – During Day – End of Day – Pain on Motion.

Low Back: Weakness – Pain – Stiffness – Swelling – Limited Movement – Pain on Motion – Surgery.
Pain When: Sitting – Walking – Standing – Sleeping. Worse: After Sleeping – During Day – End of Day.
Sacroiliac – Tailbone – Sex Impotency – Pain in Groin. Worse: After Sleeping- During Day – End of Day.

Extremities & Radiating Pain

Head & Headache: Side – Front – Top – Back of Head – Heavy Head – Affects Vision – Produces Nausea – Throbbing – Incapacitating – Handicaps Normal Function – Migraine. Worse: After Sleeping – During Day – End of Day.

Shoulder: Local Pain – Radiates Down Arm – Pain on Movement – Limited Movement – Pain from Neck.
Worse: After Sleeping – During Day – End of Day.

Arm: Local Pain – Radiating Pain – From Neck – On Movement – Down Arm – Numbness – Tingling – Elbow – Wrist – Fingers – Swelling – Heaviness – Cold Hands – Grip Strength Loss – Can’t Raise – Drops Things.

Hips, Knees, Legs: Local Pain – Radiating Pain – From Back - On Movement – Down Leg –
Knee (Front – Back) – Knee (Inside – Outside) – Numbness – Tingling – Knee Swelling – Ankle Swelling – Charlie Horses – Cramps – Spasms – Varicose Veins – Heaviness – Pain on Walking – Sitting – Prolonged Standing.

Feet: Swelling – Discomfort – Pain – Pain on Walking – Pain with Back Problem – Corns – Calluses – Bunions – Fallen Arch – High Arch – Toe-in-toe-out – Cold – Burn.

Muscles & Ligaments

Sprain – Pulled – Torn – Atrophy

Spine & Disc

Spine: Surgery – Arthritis – Curvature – Whiplash.

Disc: Surgery – Protrusion – Compressed – Degenerating – Deteriorating – Herniated – Ruptured.

Nerves

Burning – Numbness – Tingling – Pins and Needles – Tremor – Nervousness – Nervous Tension – Nervous Fatigue – Dizziness – Poor Equilibrium – Loss of Balance.

Energy & Fatigue

Energy: Intermittent – Constant – Occasional. **Fatigue:** Intermittent – Constant – Occasional.
Exhaustion build up – Tired upon Awakening – Exhaustion after Work – Must Rest During Day.
Walking Causes: Tiredness – Fatigue – Exhaustion.
Sleeping: Good – Fair – Poor – Poor Due to Pain – Insomnia – Falls to Sleep – Emotional Fatigue – Excessive Sleep.

Eye, Ear, Throat & Mouth

Eye: Pain – Strain – Red – Blurring – Light Hurts – Double Vision – Spots - Injury – Pressure.
Sight: Far – Near – Failing – Glasses – Contacts.
Ear: Ache – Infection – Noises – Ring – Buzzing.
Hearing: Good – Poor – Aid – Failing.
Nose: Post-nasal Drip – Bleeding – Obstruction – Sneezing - No Smell.
Throat: Sore – Dry – Hoarse – Phlegm – Enlarged Glands – Swallow.
Mouth: Bad Taste – Teeth – Breath – Gums – Sores – Eruptions – No Taste.
Teeth: Good – Bad – Abscess – Grinding – Dentures Fit: Well – Poor.

Heart & Circulation

Heart: Slow – Rapid – Pain – Palpitation – Past Attack – Coronary – Murmur – Chest Pain – Pain down Arm – Difficult Breathing.
Blood Pressure: High – Low – Irregular – Past Stroke – Paralysis: L – R.
Circulation: Good – Poor – Swelling.
Cold: Hands – Feet – Body – Varicose Veins – Hardening Arteries.
Sweats: Excess – None Hot – Cold – Night.
Blood: Problems – Disease – Anemia.

Lungs & Breathing

Lungs: Difficult Breathing – Congestion – Asthma – Emphysema – Wheezing – Bronchitis – Infection.
Cough: Blood – Phlegm – Dry – Sneezing.

Stomach, Liver, Gall Bladder and Intestinal

Stomach: Nausea – Pain – Ulcer – Vomiting Blood – Bile – Indigestion – Heartburn – Gas.
Appetite: Good – Poor – Excess.
Liver: Upset – Jaundice – Hepatitis.
Gall Bladder: Attack – Infection – Stones.
Intestines: Bloat – Mucous – Constipated – Diarrhea – Hemorrhoids – Fissures – Colitis.

Kidney, Bladder & Urination

Urine: Frequent – Difficult – Burns – Blood – Pus – Irritates – No Control – Infection – Kidney Stones – Prostate – Bedwetting.

Skin

Sensitive – Bruises – Dry – Itching – Rash – Hives – Shingles – Boils – Acne – Eruptions – Slow Healing.

General

Swollen Lymph Nodes: Neck – Underarm – Groin – Face – Pallor – Chills – Fever – Flu – Virus – Chronic Cold – Cough.
Sinus: Congestion – Headache – Sneeze – Allergies.
Weight Changes: Over – Under – Loss – Gain.

For Women Only

Menstrual: Cramps – Backache – Excess Flow – Difficult – Irregular – Tension.
Menopause: Symptoms – Hot Flashes – Estrogen.
Ovaries: Problems – Cyst – Fibroids.
Uterus: Problems – Cyst – Fibroids.
Miscarriages_______ Pregnancies______ Unable to become pregnant: Self – Husband. Currently Pregnant.

Absolutely no patients accepted for diagnosis or treatment of Cancer. Suspected cases of Cancer are immediately referred.

Patient Signature ________________________________ Date ____________________

Guardian Signature ______________________________