



## new patient questionnaire

Please take a few minutes to complete this form so we can get to know you better.

What is your understanding of why you have been referred to my office? \_\_\_\_\_

**CURRENT PROBLEMS:** Please list the problems/complaints you are currently experiencing. Which one bothers you the most? (# \_\_\_\_\_)

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_
- 5.) \_\_\_\_\_
- 6.) \_\_\_\_\_

**TREATMENT HISTORY:** Please check off  each treatment modality/intervention you have had for your current injury/illness.

<input checked="" type="checkbox"/>	Treatment Modality	Provider	Date or # of Visits	Was this helpful to you?
	Physical Therapy (land)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Pool Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Occupational Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Massage			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Acupuncture			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Osteopathic Manipulation			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Chiropractic			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Dry Needling/Prolo Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	TENS or Interferential Unit			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	<u>Surgery(s):</u>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	<u>Injection(s):</u>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Trigger Point Injections			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Steroid Injection(s)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Facet or SI Injections			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
	Selective Nerve Block(s)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

Epidural Steroid Injection(s)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Sympathetic or Stellate Ganglion Block(s)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
<u>Behavioral Interventions:</u>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Psychotherapy/Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Biofeedback			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Psychological Evaluation			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

What providers are you *currently* seeing? \_\_\_\_\_

Are you satisfied with your providers and current medical care?  Yes  No; please explain: \_\_\_\_\_

Are you currently performing a home exercise program? \_\_\_\_\_

Any upcoming surgeries, injections, or other procedures planned? \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_

**CURRENT MEDICATIONS:** Please list all medications (prescription and over-the-counter) you are taking.

Medication Name	Dose (mg)	Time(s)/Day	Prescribing Physician	Is this med helpful?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

Are you currently taking any vitamins, homeopathic, or herbal supplements?  No  Yes; please list: \_\_\_\_\_

Do you have any allergies to medications, latex, or adhesives?  No  Yes; please list: \_\_\_\_\_

**MEDICAL HISTORY:** Any prior surgeries, medical conditions/illnesses, or hospitalizations, not listed above? \_\_\_\_\_

Any significant **family** medical history (e.g. high blood pressure, diabetes, cancer, stroke, heart disease, neurological problems, autoimmune disease, thyroid problems, etc.)? \_\_\_\_\_

Section I-Patient Information			
Last Name		First Name	Middle Initial
<input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Social Security Number	Date of Birth
Home Address		City	State Zip
Home Phone	Cell Phone	May we leave messages regarding appointments? Yes ___ No ___	Email (Optional)
Occupation	Current Employer		Current Work Phone #
Current Employer's Address City/State/Zip		Male ___ Female ___	Driver's License Number
Is this visit related to a work injury? Yes ___ No ___ If yes, date of injury: _____ and complete Sections II & VI Is this visit related to an auto injury? Yes ___ No ___ If yes, date of accident: _____ and complete Sections III, IV, & VI If this visit is not related to either of the above, please complete Sections IV, V, & VI			
Section II-Worker's Compensation Information (Must be completed in order to bill Worker's Compensation claims)			
Employer at time of injury (if different from above)		Employer's address/City/State/Zip	
Employer's Current Phone	Claim Number	Insurance Company's Name	
Name of Adjustor or Claims Representative			Adjustor's Phone
Section III-Auto Insurance Information (Must be completed in order to bill Auto Insurance claims)			
Insurance Company's Name		Insurance Company's Address/City/State/Zip	
Adjustor's Name		Adjustor's Phone Number	Claim Number
Section IV-Primary Insurance Information (Must be filled out or patient may be responsible for payment. Your insurance card must be copied for your file.)			
Insurance #1 Name		Address City/State/Zip	Phone
Co-pay amount	Policy Holder's Last Name	First Name	Relationship
Type of Coverage (HMO, POS, etc.)	Group Number		ID or Member Number
Section V- Secondary Insurance Information (Must be filled out if there is a secondary or supplemental insurance. Your insurance card must be copied for your file.)			
Insurance #2 Name		Address City/State/Zip	Phone
Co-pay amount	Policy Holder's Last Name	First Name	Relationship
Type of Coverage (HMO, POS, PPO, etc.)	Group Number		ID or Member Number
Section VI-Referral Source			
Referred By		Referral Source Address City/State/Zip	Referral Source's Phone
Section VII-Emergency Contact Information (Optional)			
Name	Phone	Relationship	May we contact this person in case of emergency? Yes ___ No ___
Authorization of Payment for Services		Authorization for Release of Medical Records: <i>Please initial one</i>	
<p>A photocopy of this authorization shall be as valid as the original from the initial date of completion. This consent is valid until specifically revoked in writing.</p> <p>I authorize payment of medical and/or behavioral health benefits to the Behavioral Medicine Center for services provided by Dr. Rebecca Hawkins.</p>		<p>_____ Work Related Illness or Injury: I authorize the release of any medical or other information necessary to process claims pertaining to my occupational illness/injury.</p> <p>_____ Non-work Related Illness or Injury: I authorize the release of any medical or other information necessary to process claims for services provided. I also agree to pay all copayments or deductibles as per my insurance plan as well as reasonable fees if my account is turned over to collections for non payment.</p>	
<p>X _____ Signature Date</p>		<p>X _____ Signature Date</p>	