Patient Information

Name: _____
Last First MI

Email address: _____

☐ I wish to opt out of any clinic updates via email. This includes: newsletters, deals, coupons, and promotions.

Street Address: _____ City _____ State _____ Zip _____

PO Box: _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Military History: ❑Active ❑ Veteran ❑ N/A

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

If you heard from a friend, who? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

SIGNATURE (X) _____ **DATE:**_____

New Patient Questionnaire (Health Care Analysis)

Today's Date: _____

First Name:	**Last Name:**	**Email:**	
_____	_____	_____	
Address:		**City:**	**State:** **Zip Code:**
_____		_____	_____ _____
Home Phone:	**Work Phone:**	**Cell Phone:**	**Date of Birth:**
_____	_____	_____	_____
Age:	**Height:**	**Weight:**	**Gender:**
_____	_____	_____	☐ **Male** ☐ **Female**
How did you hear about us?:		**If referred by someone, who?:**	
_____		_____	

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: _____

How important to you is it to lose weight?: _____

What important reason, special occasion, or goal date do you have to lose weight?: _____

_____

How many pounds would you like to lose?: _____ How fast do you want lose the weight?: _____

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: _____

What kinds of diets have you tried on your own?: _____

What is the longest you have been able to stick with a diet?: _____

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: _____

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

_____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**

Notes:

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Hormonal Cancer
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication
- ☐ Vegetarian

If you checked any of the above, please explain: _____

_____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

Symptom Survey

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

☐ ☐ ☐ ☐ Inability to lose weight
☐ ☐ ☐ ☐ Food cravings
☐ ☐ ☐ ☐ Binge eating
☐ ☐ ☐ ☐ Nausea or vomiting
☐ ☐ ☐ ☐ Water retention

Hormone:

☐ ☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ ☐ Weight gain
☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Depression/ anxiety
☐ ☐ ☐ ☐ Mental fuzziness
☐ ☐ ☐ ☐ Memory problems
☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Decreased libido
☐ ☐ ☐ ☐ Aggression
☐ ☐ ☐ ☐ Hot flashes and/or night sweats

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches

Emotional and Mental:

☐ ☐ ☐ ☐ Depression
☐ ☐ ☐ ☐ Anxiety
☐ ☐ ☐ ☐ Mood swings
☐ ☐ ☐ ☐ Irritability
☐ ☐ ☐ ☐ Poor concentration

Skin Conditions:

☐ ☐ ☐ ☐ Acne /acne scars
☐ ☐ ☐ ☐ Sagging skin
☐ ☐ ☐ ☐ Fine lines and wrinkles
☐ ☐ ☐ ☐ Loss of volume
☐ ☐ ☐ ☐ Enlarged pores
☐ ☐ ☐ ☐ Lip lines

Hair Conditions:

☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Thinning hair
☐ ☐ ☐ ☐ Receding hair

Muscle & Joint:

☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Foot trouble
☐ ☐ ☐ ☐ Low back pain
☐ ☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ ☐ Headaches
Pain or numbness in:
☐ ☐ ☐ ☐ Shoulders
☐ ☐ ☐ ☐ Arms
☐ ☐ ☐ ☐ Elbows
☐ ☐ ☐ ☐ Hips
☐ ☐ ☐ ☐ Legs
☐ ☐ ☐ ☐ Knees
☐ ☐ ☐ ☐ Sciatica

Energy:

☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Lethargy
☐ ☐ ☐ ☐ Restlessness
☐ ☐ ☐ ☐ Insomnia
☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

☐ ☐ ☐ ☐ Irregular heartbeat
☐ ☐ ☐ ☐ Chest pains
☐ ☐ ☐ ☐ Muscle aches

Please list any symptoms you experience that were not previously mentioned: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The treating medical provider, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the medical provider. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. Any prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Physical Medicine.

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of Northwoods Family Physical Medicine to leave reminder messages on voicemail/answering machines, or with another person in the household. I may make a request of an alternative means of communication (within reason) in writing.

May we discuss your medical condition with any member of your family?	YES	NO
May we discuss your billing information with any member of your family?	YES	NO

If YES, please name the members allowed:

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date