REVITALIZE MEDICAL CENTER

Welcome to our Practice!

How did you hear about us?

☐ Referral from _____

PATIENT DEMOGRAPHIC INFORMATION			
Name			Date of Birth
Last 4 of Social Security Number	Gender □M □F	Weight Height	Marital Status □ Single □ Married □ Partner □ Divorced □ Widow
Referring Physician Name, Phone #		Primary Care Physician Name, Phone #	
Employment Status □Employed □Unemployed □Student □Retired □Military □Disability			Employer/School Name
PRESCRIPTION PLAN			
Name, Phone #		ID#	Group #
PREFERRED PHARMACY NAME/ADDRESS:			

IS THIS A WORKMAN'S COMPENSATION OR MOTOR VEHICLE CLAIM?			□Yes □No
Date of Accident	Adjustor Name	Company Name/Phone #	Claim #

NEW PATIENT INTAKE FORM

Please list all medical issues you are being treated for:

FAMILY HISTORY: Please list all health issues in your parents and/or siblings

GENERAL HISTORY:

Are you allergic to anything (medication, food, or latex?) ☐ **Yes*** ☐ **No** ***If yes, describe:**

Are you allergic to Iodine or Shellfish? ☐ **Yes*** ☐ **No** ***If yes, describe reaction:**

Please list any blood thinners you take: (aspirin, heparin, Coumadin etc.)

PREVIOUS SURGERIES/HOSPITALIZATIONS/INJURIES

(List all with approximate dates)

	Date
	/ /
	/ /

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SUBSTANCE USE

(Which of the following drugs or substances do you use currently or have used in the past?)

Alcohol How much?	Current ❒ Yes ❒ No Per Week ___	Past ❒ Yes ❒ No Per Week ____	**Heroin/Cocaine/ Amphetamines (please circle)**	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No
Marijuana	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No	**Other drugs:**_____ _	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No
Cigarettes	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No	If "yes" to either, how many packs do you/did you smoke per day? _____ If you quit, how long has it been? _____		

DOMESTIC SITUATION

Are you currently working? Part-time vs full time?	*❒ Yes ❒ No	*If Yes, occupation:
Are you able to care for yourself?	❒ Yes *❒ No	*If No, enter name of caregiver: _____

Please list all herbal supplements/vitamins including doses and frequency.

Please list all prescription and over the counter medications, including doses and frequency.

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PAIN HISTORY

When and how did your pain start? (i.e., suddenly, gradually, or injury)

Has it gotten better or worse since it started?	Approximate Date Pain Began / /

What treatments have you tried in the past for your pain?	Which position is worse? (Mark all that apply) ❒ Sitting ❒ Standing ❒ Walking

Please circle if you have any of the following and list the date of exam:

X-Ray	**CT Scan**
MRI	**EMG/Nerve Test**

Circle all of the words that describe your pain:

Sharp	Aching	Intermittent	Nagging	Throbbing	Tender
Shooting	Numb	Burning	Tingling	Stabbing	Continuous

Please rate your pain **during the last month** by circling the number that best describes your pain at its:

Worst	0	1	2	3	4	5	6	7	8	9	10
Least	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10

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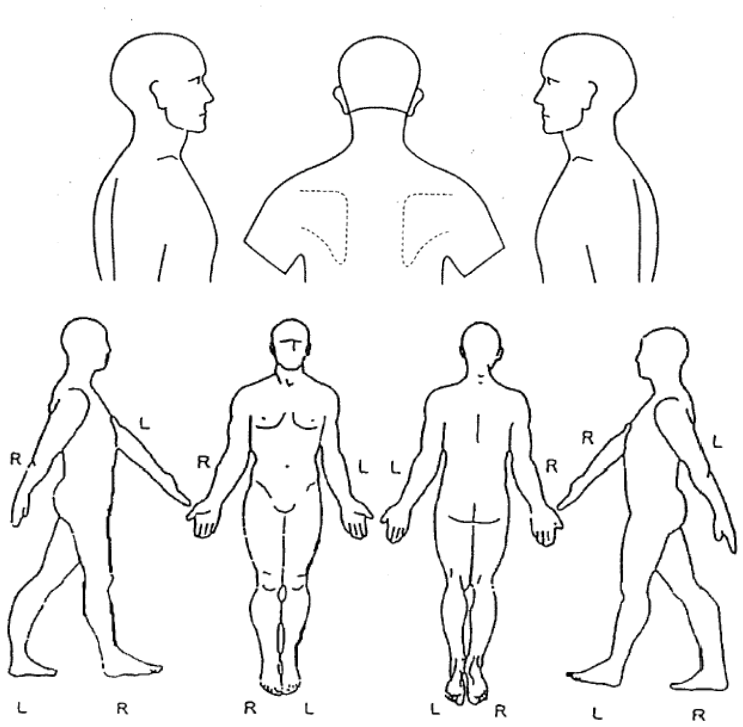
Please mark below the location of your pain



Please circle Yes or No if you are currently experiencing the following:

Fever	YES/NO	Blood in urine	YES/NO
Fatigue	YES/NO	Numbness/tingling	YES/NO
Blurry Vision	YES/NO	Weakness	YES/NO
Eye Pain	YES/NO	Muscle pain	YES/NO
Trouble Hearing	YES/NO	Headaches	YES/NO
Irregular heartbeat	YES/NO	Seizures	YES/NO
Fainting	YES/NO	Difficulty sleeping	YES/NO
Loss of Balance	YES/NO	Anxiety	YES/NO
Trouble breathing	YES/NO	Depression	YES/NO
Cough	YES/NO	Suicidal thoughts	YES/NO
Heartburn	YES/NO	Bleeding	YES/NO
Diarrhea	YES/NO	Anemia	YES/NO
Nausea/vomiting	YES/NO	Pain with urination	YES/NO

What physical activities do you participate in & how often?

_____

Describe your sleep: include # hours/night

_____

What are the major stressors in your life?

_____

What types of complementary & alternative medicine have you tried in the past?

_____

_____

Nutrition History

How many servings of fruit/vegetables do you usually eat/drink each day?

_____

How much red meat do you eat per week?

_____

How much fish/seafood do you eat per week?

_____

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NEW PATIENT QUESTIONNAIRES

GAD **Over the last 2 weeks, how often have you been bothered by the following problems?**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

PHQ – 9 **Over the last 2 weeks, how often have you been bothered by the following problems?**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Date of Birth:	Phone:	Email:	Last 4 SSN:
Street Address:	City:	State:	Zip Code:

I hereby authorize:

Name of Physician/Individual/Organization _____
To disclose to: **REVITALIZE MEDICAL CENTER**

Phone: (847) 834-4018

Fax: (847) 834-4944

The following information:

☐ Please release my entire record

-OR-

☐ Please release only the following information

_____

Release of Records Disclosure

- I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, developmental disabilities, or treatment for alcohol and/or drug abuse.
- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that this authorization is voluntary. I understand that the person(s) or organization(s) authorized to make requested use and/or disclosure may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of an authorization.
- I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to REVITALIZE MEDICAL CENTER. I understand the revocation will not apply to information that has already been released in response to this authorization.
- Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate in two years from this date.

Patient/Patient Representative Signature Date

_____ _____