Musculoskeletal Medicine & Pain Management Associates, P.C. DBA "Multicare"

New Patient Information 6/5/17 UPDATED

Welcome! Please allow our staff to photocopy your driver's license & insurance card (if applicable)

PLEASE PRINT CLEARLY: Today's Date: ____/____/20____

Patient Name: ______________________________________ Social Security #: ______________________

E-mail: ________________________________ Gender: M F Age:___ DOB: ___/___/___

Address: ____ City: ________________ Zip Code__________

We need your street address as well if you have a PO BOX

Contact Information & Permissions

Home Phone: (____) ______________ Cell Phone: (____)______________ Work Phone: (___)______________

E-mail: _________________________ May we e-mail you? ◯ Y ◯ N May we contact you at work? ◯ Y ◯ N

May we leave voicemail on Home / Cell phone: ◯ Y ◯ N **Permissions can be changed at any time upon request**

Personal Information

Work Status: ◯ FT ◯ PT ◯ R ◯ Student Marital Status: ◯ S ◯ M ◯ D ◯ W # Children: _____

Employer: ____________________________ Occupation: ____

Employer Address: ____ City: _____________________________

State: _____ Zip: _________

Females: Last Menstrual Period: ____/____/____ Pregnant: ◯ Y ◯ N Nursing: ◯ Y ◯ N

Spouse, Parent or Guardian Name: _________________________________ Age: ____ DOB: ____/____/____

Spouse/Parent/Guardian Employer: ______________________________ Occupation: ______________________

Spouse/Parent/Guardian Work Phone: (_____)___________________

Emergency Contact

Emergency Contact Person 1: _____________________________ Relationship to Patient: ___________________

Home Phone: (___)______________ Cell Phone: (___)_______________ Work Phone: (___)______________

Emergency Contact Person 1: _____________________________ Relationship to Patient: ___________________

Home Phone: (___)______________ Cell Phone: (___)_______________ Work Phone: (___)______________

Insurance Information

Do you have health insurance: ◯ Y ◯ N Carrier Name: __________________ Group Name:_______________

Policy #: _________________________________ Group #: ________________________

◯ Ins Card Copied ◯ DL Copied

Notice of Financial Responsibility
If there is insurance coverage that will be submit for processing for treatment and services received at this practice, patient understands that insurance benefits are not guaranteed and coverage for payment is determined when claims are received and processed. Any verification of benefits provided is only an estimate of coverage. Patients are encouraged to contact insurance payers directly to learn more about your individual policy benefits and limitations.
Please sign below to acknowledge patient responsibility for the patient portion of insurance charges and/or payment in full for non-covered items or services. If there is no insurance coverage, patient is responsible for the balance due for services at the time of service for each visit.

____ _____________________
Patient/Guardian/Authorized Party Signature *Date*

Is this visit related to an Accident? Work _____ Car_____ Other _____
If this is an accident do you have an attorney? If so please provide name ______________________________

How did you hear about us? ◯ Yellow Pages ◯ Website ◯ Friend / Family member
◯ Doctor- Name of Dr __________________________________ ◯ Other _________________________

Health Information:

Health Concerns: (please list in priority order & use back of questionnaire or additional paper if needed)

1.____

2.____

3. ____

Treatment: What type of treatment are you looking for?
◯ **Symptom Relief** ◯ **Correctional Care** ◯**Total Wellness Care** ◯ **All 3 previous choices**

Symptoms/Complaints: (relating to your primary complaint(s)

When did Symptoms begin? ______________ What initiated symptoms? ______________________________

____

Have you previously been treated for this condition by another provider? ◯ Y ◯ N

If yes, by whom? __________________________ Treatment received: _______________________________

Have you had any reactions to previous treatment: ◯ Y ◯ N

Describe: ____

If this is a recurrence, when did you initially notice this problem? ____________________________________
Has worsened over time: ◯ Y ◯ N ◯ Same ◯ Better ◯ Worse
How long does it last? ◯ All day ◯ Hours ◯ Minutes
Is this condition interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

◯ Other: ____

Describe the symptoms (check all that apply): ◯ Pain ◯ Sharp ◯ Dull ◯ Numbness ◯ Tingling
◯ Aching ◯ Burning ◯ Stabbing ◯ Stiffness ◯ Other: ______________________________

What makes the problem worse?: ◯ Standing ◯ Sitting ◯ Lying ◯ Bending ◯ Lifting ◯ Twisting
◯ Other: ____

Have you found things that relieve symptoms? ◯ Y ◯ N If yes, describe: ________________________
Do you have other conditions or symptoms that may be related to current symptoms? ◯ Y ◯ N
If yes, what?____

Have you ever been in an auto accident or other physical trauma: ◯ Past year ◯ 1-5 years ◯ 5+ years
◯ Never Describe:____

Please mark all other applicable health related symptoms or conditions as they apply:

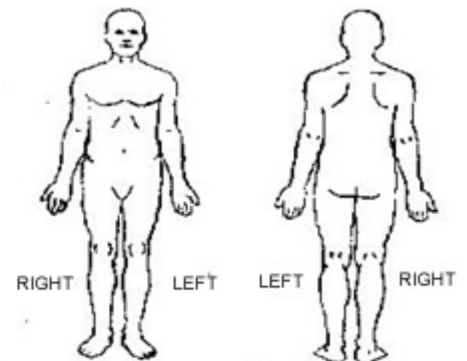
◯ Headache
◯ Facial Pain
◯ Blurred Vision
◯ Dizziness
◯ Earache
◯ Eye pain
◯ Forgetfulness
◯ Confusion
◯ Sinusitis
◯ Teeth Grinding
◯ Dry Mouth
◯ Excessive Thirst
◯ Unpleasant Taste
◯ Neck Pain
◯ Sore Throat
◯ Lump in Throat
◯ Swallowing Pain
◯ Unsteady Voice
◯ Shoulder Pain
◯ Persistent Coughing
◯ Chest Pressure
◯ Slow Heart Rate
◯ Rapid Heart Rate

◯ High Blood Pressure
◯ Low Blood Pressure
◯ Abdominal Pains
◯ Nausea/Vomiting
◯ Poor Appetite
◯ Fullness of Bladder
◯ Urination Difficulty
◯ Frequent Urination
◯ Constipation
◯ Hemorrhoids
◯ Decreased Sex Drive
◯ Menstrual Irregularities
◯ Elbow/Hand Pain
◯ Tingling in Hands
◯ Clammy Hands
◯ Low Back Pain
◯ Hip Pain
◯ Knee Pain
◯ Poor Circulation
◯ Swollen Joints
◯ Joint Stiffness
◯ Swollen Ankles
◯ Ankle/Foot Pain

◯ Tingling in Feet
◯ Walking Problems
◯ Sore Muscles
◯ Weak Muscles
◯ Paralysis
◯ Shakiness
◯ Sweating
◯ Insomnia
◯ Fainting
◯ Convulsions
◯ Irritability
◯ Impatience
◯ Fatigue
◯ Feel Loss of Control
◯ Other: ___________
____

*__Additional__ *
(Please check all that apply)
◯ Seizures (Epilepsy)
◯ Transplant
◯ Surgically Implanted Device
◯ Pacemaker

Please use the legend symbols below to accurately mark the areas in which you feel symptoms or discomfort.



Scars/Surgical Procedures (Please list all):
____

Miscellaneous & Habits:

Are you: ◯ Left handed ◯ Right handed ◯ Ambidextrous

Exercise: ◯ Light ◯ Moderate ◯ Heavy

Exercise Type: ____ Frequency: _________________________

Approximately how many hours do you sleep per night? ______

Uninterrupted Sleep: ◯ Y ◯ N   Do you feel rested upon waking? ◯ Y ◯ N   Vivid Dreams? ◯ Y ◯ N

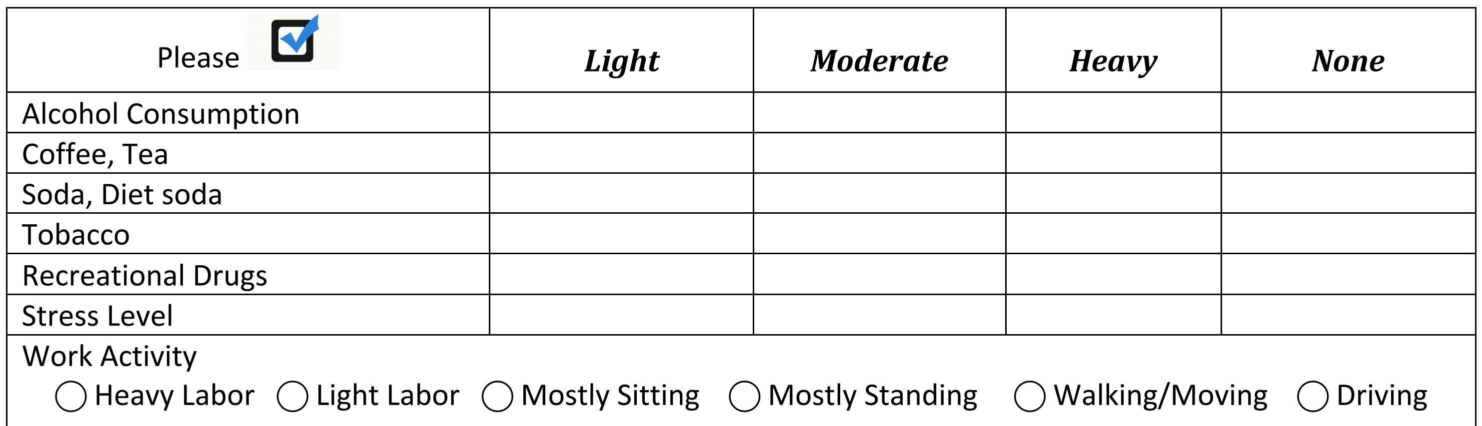
How many meals per day do you eat? ________ How much water per day do you drink: __________________

How many bowel movements do you have each day? _____________

Personal & Family History Identify conditions that you or any of your family members have now or have previously had.

(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

_____Allergies
_____Alcoholism
_____Anemia
_____Cancer
_____Deep Vein Thrombosis
_____Detached Retina
_____Diabetes
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart Disease
_____HIV/AIDS
_____Miscarriage(s)
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic Fever
_____Stroke
_____Tumor(s)
_____Ulcer(s)
_____ Female Organ Dysfunction
_____ Over weight
_____Headaches/migraines
_____ Addiction
_____ other: ________________



Please ☑	*Light*	*Moderate*	*Heavy*	*None*
Alcohol Consumption				
Coffee, Tea				
Soda, Diet soda				
Tobacco				
Recreational Drugs				
Stress Level				
Work Activity ◯ Heavy Labor ◯ Light Labor ◯ Mostly Sitting ◯ Mostly Standing ◯ Walking/Moving ◯ Driving				

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Current Medications (Include - all Prescriptions and over the counter including Vitamins)			
Prescribing Dr.	Name of Medication	Dose	Frequency

Allergies/Sensitivities: (please check and list all that apply)	Description	Reaction
◯ Medications ◯ Food ◯ Seasonal ◯ Other		

Patie
nts Name ____________________________________Date__________________

Date Med list was updated by patient___________________ Initial___________________
Date Med list was updated by patient___________________ Initial___________________
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