WELCOME

Patient Information

Date: _____ MP_____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

(City) _____ (State) _____ (Zip) _____

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 ❑ Partner

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

Number of Children and ages_____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

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

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to a recent accident? ❑ Yes ❑ No If yes, Is there an open claim? ❑ Yes ❑ No

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Name: _____ Date: _____

Health History

Who is your primary care physician? (Doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

What is your chief complaint or primary reason for your visit? _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Review of Systems

Name_____ **Date**_____

Please circle YES or NO if you have experienced any of these symptoms recently:

Yes	No	**Neurological**
Y	N	Migraines
Y	N	Headaches
Y	N	Slurring of speech
Y	N	Ringing in Ear

		Ear/Nose/Throat
Y	N	Altered taste/smell
Y	N	Night Blindness
Y	N	Sore Throat
Y	N	Gingivitis
Y	N	Nose bleeds

		Cardiovascular
Y	N	Chest pain
Y	N	Palpitations-racing heart beat
Y	N	Swelling in hands/feet
Y	N	Anemia

		Respiratory
Y	N	Recurrent Respiratory Infections
Y	N	Asthma
Y	N	Chest Congestion
Y	N	Wheezing
Y	N	Frequent Sneezing

		GI
Y	N	Stomach Pains or Cramping
Y	N	Constipation
Y	N	Reflux or Heartburn
Y	N	Bloating
Y	N	Gas
Y	N	Nausea or Vomiting

		Musculoskeletal
Y	N	Joint Pain
Y	N	Arthritis
Y	N	Chronic pain
Y	N	Muscle Aches

Yes	No	**Skin**
Y	N	Eczema
Y	N	Dermatitis
Y	N	Excessive Sweating
Y	N	Rashes
Y	N	Brittle Nails
Y	N	Hair Loss
Y	N	Easy Bruising
Y	N	Increased Bleeding
Y	N	Numbness/tingling

		Genitourinary
Y	N	Uterine fibroids
Y	N	Ovarian cysts
Y	N	Cancer (breast, ovarian, prostate, uterine)
Y	N	Prostate problems

		Emotional/Mental
Y	N	Depression
Y	N	Anxiety
Y	N	Mood Swings
Y	N	Irritability
Y	N	Memory Loss
Y	N	Confusion

		Energy
Y	N	Fatigue
Y	N	Hyperactivity
Y	N	Restlessness
Y	N	Insomnia
Y	N	Decreased Libido
Y	N	Stress

		Weight
Y	N	Decreased Appetite
Y	N	Weight Gain
Y	N	Inability to Lose Weight
Y	N	Food Cravings
Y	N	Binge Eating
Y	N	Water Retention

Food Intolerance and Sensitivity Survey

Date: ___/____/_____

Patient Name: _____

Gender: M/F

Height: Feet_____ Inches_____

Weight: _____lbs.

Please list all medications you are currently taking: _____

_____

Please complete the following food intolerance and sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days.

Symptom Scoring System:

● O O O = No Symptoms (Zero Points)

O ● O O = Experience Mild Symptoms (One Point)

O O ● O = Experience Moderate Symptoms (Two Points)

O O O ● = Severe Symptoms (Three Points)

Digestive Symptoms

O O O O Stomach Pains or Cramping
O O O O Constipation
O O O O Diarrhea
O O O O Reflux or Heartburn
O O O O Bloating
O O O O Gas
O O O O Nausea or Vomiting

Weight

O O O O Inability to Lose Weight
O O O O Food Cravings
O O O O Binge Eating
O O O O Water Retention

Sinus/Respiratory

O O O O Stuffy or Runny Nose
O O O O Asthma
O O O O Chest Congestion

Head/ Ears

O O O O Migraines
O O O O Headaches
O O O O Earaches
O O O O Ear Infection
O O O O Ringing in Ears

Eyes/Throat

O O O O Itchy Eyes
O O O O Watery Eyes
O O O O Sore Throat
O O O O Persistent Canker Sores

Emotional/Mental

O O O O Depression
O O O O Anxiety
O O O O Mood Swings
O O O O Irritablility
O O O O Poor Concentration

Energy

O O O O Fatigue
O O O O Hyperactivity
O O O O Lethargy
O O O O Restlessness
O O O O Insomnia

Skin Disorders

O O O O Eczema
O O O O Dermatitis
O O O O Rashes
O O O O Hives

Other Symptoms:

O O O O Joint Pain
O O O O Arthritis
O O O O Irregular Heartbeat
O O O O Chest Pains
O O O O Muscle Aches

Please list any symptoms not mentioned:

_____

Total Score: _____

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 doctor, 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 physician.

I agree that any claim or dispute, that I may have with and/or against any of these persons and/or entities, will be resolved and finalized between the patients' legal officials and Superior Healthcare Physical Medicine authorized delegates.

_____ _____

Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This **Notice of Privacy Practices** identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

Please initial below:

_____ I acknowledge that it is the policy of Superior Healthcare to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question regarding my rights, I may speak with the Front Desk about my concerns to be forwarded to the appropriate department.

The undersigned certifies that he/she has read the foregoing, received a copy of the **Notice of Privacy Practices** and is the patient, or the patient's personal representative.

Name of Patient	Signature of Patient Date
Name of Patient's Personal Representative	Signature of Representative

Please list any parties that may be allowed access to your personal health/financial information below:

Printed Name	Relationship

FOR INTERNAL USE ONLY

Signature of Office Representative	Date Signed