PREMIER HEALTHCARE OF PLACERVILLE, INC.

NEW PATIENT QUESTIONNAIRE

PATIENT DEMOGRAPHIC/ INFORMATION Date:___/____/_____

First Name: _____MI:_____ Last Name:_____

Address:_____City:_____State:_____Zip:_____

Hm Phone#:_____Cell Phone#:_____Work Phone#:_____

SS#:_____DL#:_____

AGE:____DOB____/____/_____SEX_____MARITAL STATUS : M☐ S☐ D☐ W☐

EMAIL ADDRESS: _____

Spouse's Name:_____DOB____/____/_____Employer_____

Whom may we contact in case of emergency?_____Phone#:_____

Whom may we thank for referring you?_____

INSURANCE INFORMATION (Please supply copy of Insurance Card and ID.)

Medicare: Yes☐ No☐ Medi-Cal: Yes☐ No☐ Other Ins.:_____

Insured Person's Name: _____Insured's Employer:_____

Insured Person's DOB:____/____/_____Insured's SS#:_____

ID#_____Group#:_____

SYMPTOM INFORMATION:

1.) What is hurting you?

2.) When did your symptoms begin?

3.) How did you become injured?

4.) Rate your pain (PLEASE CIRCLE): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (out of 10).

5.) Describe your pain (PLEASE CIRCLE): SHARP, STABBING, ELECTRICAL, DULL, TINGLING.

6.) Are you ALLERGIC to anything?

7.) What medications do you take?

8.) Have you had any surgeries?: Yes ☐ No ☐ If yes, please list:

9.) Have you recently had (PLEASE CIRCLE): MRI, XRAY, CT SCANS? Please list the dates and **locations** where they were performed.

10.) Which of the following have you tried? (PLEASE CIRCLE): PHYSICAL THERAPY, CHIROPRACTIC, TENS/H-WAVE, MASSAGE, HEAT & ICE, ACUPUNCTURE, SUPPORTS, OTHERS_____.

11.) Please list any other medical problems that you would like to discuss?

12.) Are you married?: Yes ☐ No ☐ Do you have any children?: Yes ☐ No ☐

Do you smoke?: Yes ☐ No ☐

13.) Do you have a history of drug or alcohol addiction?: Yes ☐ No ☐

14.) Do you chronically have any of the following? (PLEASE CIRCLE): WEIGHT GAIN, WEIGHT LOSS, DIARRHEA, CONSTIPATION, HEADACHES, DIFFICULTY GOING TO SLEEP, DIFFICULTY STAYING ASLEEP, DIFFICULTY SWOLLOWING, DIFFICULTY BREATHING, VISUAL PROBLEMS, SEIZURES, STOMACH UPSET, BALANCE ISSUES, HEARING ISSUES, FATIGUE.

15.) **Are we seeing you for a WORK related injury?:** Yes ☐ No ☐

16.) **VITAL SIGNS (MA only): B/P _____/_____, RESP _____, PULSE_____**

17.) **(MA only) DRUG SCREEN: YES ☐ NO ☐**

PATIENT SIGNATURE: _____DATE____/____/_____