

PREMIER HEALTHCARE PLACERVILLE, INC.

PATIENT INTAKE FORM / QUESTIONNAIRE

Date: ___/___/___

Page 1

(Legal) First Name (Legal) MI (Legal) Last Name DOB Age
Street Apt City State Zip
SS#: MARITAL STATUS : [] S [] M [] W [] D Spouse
DL#:

Language: ___ English ___ Spanish ___ Indian ___ Japanese ___ Chinese ___ Korean ___ French ___ German ___ Russian Other

Race/Ethnicity: ___ White ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian/Other Pacific Islander
___ Black or African American ___ Hispanic or Latino ___ Decline to Answer

Contact Info: Home Ph: Work Ph: Cell Ph:

Cell Carrier: Email Hm:

Email Wk:

Contact Preference: ___ Home Ph ___ Work Ph ___ Cell Ph ___ Text ___ Email Hm ___ Email Wk ___ Postal Mail

Emergency contact: Phone:

Who Referred you to our office? Phone:

Occupation: Employer:

Employer's Address: Street City State Zip

INSURANCE INFORMATION (Please supply copy of Insurance Card and one form of picture ID)

Medicare: Yes No Medi-Cal: Yes No Group Ins.:

Policy Holder's Name: Policy Holder's Employer:

Policy Holder's DOB: ___/___/___ Policy Holder's SS#:

ID# Group#:

Secondary Insurance:

Policy Holder's Name: Policy Holder's Employer:

Policy Holder's DOB: ___/___/___ Policy Holder'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.

PREMIER HEALTHCARE PLACERVILLE, INC. NEW PATIENT QUESTIONNAIRE

- 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 How Many?
- 13.) Do you smoke?: Yes No
- 14.) Do you have a history of drug or alcohol addiction?: Yes No
- 15.) 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 SWALLOWING, DIFFICULTY BREATHING, VISUAL PROBLEMS, SEIZURES, STOMACH UPSET, BALANCE ISSUES, HEARING ISSUES, FATIGUE.
- 16.) Are we seeing you for a WORK related injury?: Yes No (Complete Worker's Comp Questionnaire)
- 17.) VITAL SIGNS (MA only): B/P _____/_____, RESP _____, PULSE _____
- 18.) (MA only) DRUG SCREEN: YES NO
- 19.) PATIENT SIGNATURE: _____ DATE ____/____/____