Putting HEALTH back in Healthcare!

How did you hear about A New Direction Health & Wellness?
Facebook
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Family Member
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Healthcare Provider

Patient personal information
First name:
Last name:
Date of birth:
Gender:

Patient contact information
Street address:
City:
State:
Zip:
Country:
Email:
Phone:

Emergency contact information
First name:
Last name:
Street address:
City:
State:
Zip:
Country:
Email:
Phone:

Preferred language

Ethnicity

Race

Insurance
Insurance company name:
Insurance plan:
Insurance ID:
Effective date:
Please provide a copy of Front and Back of Insurance Card

Preferred Pharmacy
Name:
Address:
Phone number:

Smoking Status:

- Non smoker
- Ex-smoker
- Ex user of moist powdered tobacco
- Current non smoker but past smoking history unknown
- Light cigarette smoker (1-9 cigs/day)
- Moderate cigarette smoker (10-19 cigs/day)
- Heavy cigarette smoker (20-39 cigs/day)
- Very heavy cigarette smoker (40+ cigs/day)
- Cigar smoker
- Pipe smoker
- Chews tobacco
- Chews products containing tobacco
- Snuff user

Alcohol Consumption:
How often do you have a drink containing alcohol?

- Never
- Monthly, or less
- 2-4 times per month
- 2-3 times per week
- 4 or more times per week

Alcohol Consumption:
How many standard drinks containing alcohol do you have on a typical day?

- 1-2
- 3-4
- 5-6
- 7-9
- 10 or more

Alcohol Consumption:
How often do you have 6 or more drinks on 1 occasion?

- Never
- Less than monthly
- Monthly or less
- Weekly
- Daily or almost daily

Educational Background: (Select Highest Level Completed)

- Never attended; or Kindergarten only
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade; no diploma
- High School Graduate
- GED; or equivalent
- Some college; no degree
- Associate Degree: occupational, technical, or vocational program

- Associate Degree: academic program
- Bachelor's Degree
- Master's Degree
- Professional School Degree: MD, DDS, DVM, JD, etc)
- Doctoral Degree
- Decline to specify

Physical Activity:
How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

- 0-1 days
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

Physical Activity:
On those days that you engaged in moderate to strenuous exercise, how many minutes, on average, do you exercise?

Stress:
Do you feel stress-tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled all the time- these days?

- Not at all
- Only a little
- To some extent
- Rather much
- Very much
- Patient declined to specify

Nutrition:
Are you currently following any dietary restrictions/modifications? (Select All That Apply)

- Not currently following any dietary restrictions of modifications
- Paleo/Paleolithic
- Low Fat
- Low Carbohydrate
- Ketogenic
- Mediterranean
- Atkin's
- Weight Watchers
- Meal Service (Example: Nutrisystem)
- Food Allergies
- Food Sensitivities
- Gluten-Free
- Intermittent Fasting

Nutrition:
Caffeine Consumption*:* ***(Select One)***

- I never drink caffeinated beverages.
- I drink caffeinated beverages a couple times per year.
- I drink caffeinated beverages a couple times per month.
- I drink caffeinated beverages a couple times per week.
- I drink caffeinated beverages a couple times per day.

SOCIAL HISTORY:
Where were you born? (City, State and/or Country)

Where have you lived? (City, State and/or Country)

Current Place of Residency (City, State and/or Country)

Marital Status: (Select One)

- Single
- In a Long-Term Relationship
- Married
- Divorced
- Widowed

Other people whom I live with include: (Select All That Apply)

- Alone
- Spouse
- Significant Other
- Adult Child(ren)
- Adult Family Member(s) (Parent, Sibling, Aunt, Uncle, etc.)
- Child(ren)
- Room Mate(s)
- Pet(s)

Where have you traveled? (Please provide both location and date of travel if known)

Current Occupation:

Do you have any Hobbies or Interest?

Have you been exposed to any Toxic Substance(s): Examples: Lead, Asbestos, etc.

- No known exposure.
- Some exposure to toxic substances.
- Frequent exposure to toxic substances.

Substance Use (Select All that Apply)

- I have never tried illicit substances.
- In the past, I have tried marijuana.
- Currently, I occasionally use marijuana.
- In the past, I have tried stimulants (cocaine, ecstasy, methamphetamine, etc.).
- Currently, I occasionally use stimulants (cocaine, ecstasy, methamphetamine, etc.).
- In the past, I have tried opiates with or without a prescription.
- Currently, I occasionally use opiates with or without a prescription.
- In the past, I have tried Heroin.
- Currently, I occasionally use Heroin.

On average, how many hours of uninterrupted sleep do you get per night? (Select One)

- 0 - 2
- 3 - 5
- 6 - 8
- 9 or more

Preferred Religion:

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FAMILY MEDICAL HISTORY:
Please list any major conditions of immediate family members including spouse, children, parents, siblings, and grandparents.

PATIENT MEDICAL HISTORY:
Past Medical History: In the past, I have been diagnosed with the following conditions: (Select All That Apply)

- No Past Medical Conditions
- Hypertension
- High Cholesterol
- Arrhythmia
- Abnormal EKG
- Angina
- Heart Murmur
- Congestive Heart Failure (CHF)
- Myocardial Infarction (MI, Heart Attack)
- Stoke/Transient Ischemic Attack (TIA)
- Congenital Heart Disease
- Ankle Swelling (Edema)
- Generalized Swelling (Edema)
- Pulmonary Edema
- Asthma
- COPD
- Sleep Apnea
- Tuberculosis
- Kidney Disease
- Urinary Disorder
- Liver Disease
- Hepatitis
- Diabetes
- G6PD Deficiency
- Thyroid Disease
- GI/Stomach/Intestinal Disorder
- Menstrual Dysfunction
- Hormone Imbalance
- Anxiety or Panic Attack
- Depression
- Other Mood Disorder
- Psychiatric Disorder
- Autoimmune Disease
- Cancer
- Measles, Mumps, Rubella
- Whooping Cough
- Chickenpox
- Smallpox
- Scarlet Fever
- Rheumatic Fever
- Diphtheria
- Poliomyelitis

Have you been Hospitalized in the past? If yes, please provide reason and date(s) for hospitalization(s).

Have you undergone surgery in the past? If yes, please provide name of surgery and date(s).

Have you received a blood transfusion in the past? If yes, please provide date of transfusion.

Primary Care Provider
Name:
Address:
Phone number:

Please provide the date of your most recent visit to your Primary Care Provider.

Please provide the date of your most recent complete physical exam or All Well Visit.

Please provide the date of your most recent MINI MENTAL STATUS EXAM.

Please provide the date of your most recent EKG.

Please provide the date of your most recent spirometry test.

Please provide the date of your most recent colonoscopy.

Please provide the date of your most recent DEXA scan.

Men Only: Please provide the date and result of your most recent PSA/DRE.

Women Only: OB/GYN Provider
Name:
Address:
Phone number:

Women Only: Please provide the date of your most recent OB/GYN exam.

Women Only: Please provide the date and result of your most recent mammogram.

Women Only: Please provide the date and result of your most recent PAP.

Women Only:
Last Menstrual Period (Date):

Women Only: Pregnancy Status:
I am not currently pregnant.
I am currently pregnant.
I do not know if I am pregnant.

Women Only: Breast Feeding Status:
I am NOT currently breast feeding.
I am currently breast feeding.

Dental Provider
Name:
Address:
Phone number:

Please provide the date of your most recent dental exam.

Eye Care Provider
Name:
Address:
Phone number:

Please provide the date of your most recent eye exam.

Other Medical Providers such as Cardiologist, Nephrologist, etc.
Name:
Address:
Phone number:

Please provide the date of your most recent visit to Other Medical Provider(s) such as Cardiologist, Nephrologist, etc.

PREVENTIVE CARE:
Please check the immunizations you have received. (Select All That Apply)

- I have received all childhood vaccines.
- Varicella (VAR)
- Diptheria, Tentanus, and Pertussis (DTaP)
- Haemophilus influenza type B (Hib)
- Hepatitis A (Hep A)
- Hepatitis B (Hep B)
- Influenza (IIV)
- Measles, Mumps, Rubella (MMR)
- Inactivated Polio Virus (IPV)
- Pneumococcal (PCV13)
- Rotavirus (RV, RV1, RV5)
- Meningococcal (MenACWY-D, MenACWY-CRM)
- Human Papillomavirus (HPV)
- Pneumococcal Polysaccharide (PPSV 23)

Please provide the date of your most recent Influenza vaccination.

Please provide the date and result of your most recent Tuberculosis Test.

DEVELOPMENTAL MILESTONES:
Developmental Milestones: (Select One)

- *All developmental milestones were met at appropriate age(s).*
- *Unknown if developmental milestones were met at appropriate age(s).*

Developmental Milestones: (Select One)
Maslow's Hierarchy:
Physiological: BEING met.
Physiological: NOT being met.
Safety: BEING met.
Safety: NOT being met.
Love/Belonging: BEING met.
Love/Belonging: NOT being met.
Esteem: BEING met.
Esteem: NOT being met.
Self Actualization: NOT BEING met.

Developmental Milestones: (Select One)
Erickson's Stage:
Infant – 18 months: Trust vs Mistrust
18 months – 3 years: Autonomy vs Shame/Doubt
3 years – 5 years: Initiative vs Guilt
5 years – 13 years: Industry vs Inferiority
13 years – 21 years: Identity vs Confusion
21 years – 39 years: Intimacy vs Isolation
40 years – 65 years: Generativity vs Stagnation
65 years and older: Integrity vs Despair

Allergies
Medication Allergies:
Food Allergies:
Environmental Allergies:

Please list the names, dosage, and frequency of All Prescription Medications you are currently taking.

Please list the names, dosage, and frequency of any Over the Counter medications and/or Supplements you are currently taking.

Do you have any medically implanted devices? (Select All that Apply)

- Pacemaker
- Cardioverter – defibrillator
- Artificial heart valve(s)
- Stents
- Breast implants
- Screws
- Pins
- Plates
- Rods
- Other artificial hardware
- IUD
- Ear tubes
- Artificial eye lenses
- Other (not listed)

CURRENT HEALTH ISSUE:
Have you experienced a recent illness or injury? If yes, please provide details including dates.

Why are you seeking healthcare today?

When did your symptom(s) start?

Describe characteristics of your symptom(s) such as color, consistency, odor, etc.

How often do you experience your symptom(s)?

How long do your symptom(s) last when you experience them?

What is the location of your symptom(s)?

Do your symptom(s) spread or radiate to any other locations?

Does anything make your symptom(s) better or worse?

Do you feel your symptom(s) interfere with your daily activities?

What therapies have you tried?

Have you seen any other Healthcare professionals for this concern? If so, please provide their name and contact information if available.

Do you have any fears or concerns regarding your issue today?

What is your treatment goal?

What is your current Height (in inches)?

What is your current weight (in pounds)?

Is there any other information you feel would be relevant to your visit today?

REVIEW OF SYSTEMS:
Review of Systems: In the past 3 months have you experienced any of the following: (Select All That Apply).

GENERAL:
- *fever*
- *chills*
- *malaise*
- *fatigability*
- *night sweats*
- *unexpected weight loss*
- *unexpected weight gain*
- *trouble sleeping*

NUTRITION:
- *changes in appetite*

NEUROLOGIC:
- *dizziness*
- *syncope*
- *seizures*
- *weakness,*
- *paralysis*
- *abnormalities of sensation (numbness or tingling)*
- *abnormality of coordination*
- *tremors*
- *loss of memory*

PSYCHIATRIC:
- *depression*
- *mood changes*
- *difficulty concentrating*
- *nervousness*
- *tension*
- *suicidal thoughts*
- *irritability*
- *sleep disturbances*

SKIN, HAIR, & NAILS:
- *rash*
- *lumps*
- *itching*
- *dryness*

- *pigmentation changes*
- *texture changes*
- *excessive sweating*
- *abnormal nail growth*
- *abnormal hair growth*

LYMPH NODES:

- *enlargement*
- *tenderness*
- *suppuration (pus)*

HEAD AND NECK:

- *severe head injuries*
- *periods of loss of consciousness*
- *frequent or unusual headaches*
- *dizziness*
- *syncope (fainting)*
- *neck pain*
- *neck stiffness*

EYES:

- *wears glasses or contacts*
- *redness*
- *visual acuity change*
- *visual blurring*
- *diplopia (double vision)*
- *photophobia (sensitivity to light)*
- *pain*
- *flashing lights, specks, or floaters*
- *eye trauma*

EARS:

- *decreased hearing*
- *pain*
- *discharge*
- *tinnitus (ringing)*
- *vertigo (dizziness and spinning sensation)*

NOSE:

- *loss of sense of smell*
- *increased frequency of colds*
- *stuffiness*
- *obstruction,*
- *discharge*
- *epistaxis (bloody nose)*
- *postnasal discharge*
- *sinus pain*
- *snoring*
- *mouth breathing*

THROAT/MOUTH:

- *hoarseness or change in voice*
- *frequent sore throats*
- *bleeding of gums*
- *swelling of gums*
- *recent tooth abscesses or extractions*
- *dentures*
- *soreness of tongue*
- *soreness of buccal mucosa (inside cheeks, roof of mouth, under tongue)*
- *ulcers*
- *non-healing sores*

- *disturbance of taste*
- *dry mouth*

RESPIRATORY:

- *pain related to respiration*
- *dyspnea (difficulty breathing)*
- *cyanosis (blue coloring to lips, skin, nail beds)*
- *wheezing*
- *cough,*
- *changes in sputum character*
- *changes in sputum quantity*
- *hemoptysis (blood tinged sputum)*
- *night sweats*
- *exposure to TB (Tuberculosis)*

CARDIOVASCULAR:

- *chest pain*
- *chest discomfort*
- *tightness*
- *palpitations*
- *shortness of breath with activity*
- *orthopnea (difficulty breathing lying down)*
- *sudden awakening from sleep with shortness of breath*
- *edema*
- *hypertension*
- *calf pain when walking*
- *leg cramps*

HEMATOLOGIC:

- *tendency to bruise or bleed*

GASTROINTESTINAL:

- *change in appetite*
- *swallowing difficulties*
- *heartburn*
- *indigestion*
- *food intolerance*
- *dysphagia*
- *nausea*
- *vomiting*
- *hematemesis (vomiting blood)*
- *change in bowel habits*
- *constipation*
- *diarrhea*
- *change in color or contents of stool (clay colored, tarry, fresh blood, mucus, undigested food)*
- *flatulence*
- *yellow eyes*
- *yellow skin*

GENITOURINARY:

- *frequency*
- *urgency*
- *burning*
- *dysuria (painful urination)*
- *flank pain*
- *suprapubic pain*
- *nocturia (excessive night time urination)*
- *hematuria (blood in urine)*
- *polyuria (increased volumes or urine)*
- *hesitancy*
- *dribbling*

- *loss in force of stream*
- *passage of stone*
- *edema*
- *incontinence*
- *dark urine*

MUSCULOSKELETAL:

- *joint stiffness*
- *joint pain*
- *muscle stiffness*
- *muscle pain*
- *weakness*
- *restriction of motion*
- *swelling*
- *redness*
- *heat*
- *bony deformity*
- *trauma*

ENDOCRINE:

- *thyroid enlargement*
- *thyroid tenderness*
- *heat intolerance*
- *cold intolerance*
- *unexplained weight change*
- *polydipsia (excessive thirst)*
- *polyuria (frequent urination)*
- *polyphagia (excessive hunger)*
- *changes in facial or body hair*
- *increased hat and/or glove size*
- *skin striae (stretch marks)*

BREAST(S):

- *pain*
- *discharge*
- *lumps*
- *galactorrhea (excessive or inappropriate milk production)*

REPRODUCTIVE FEMALE*:*

- *dysmenorrhea (Painful menstration)*
- *intermenstrual bleeding or discharge*
- *itching*
- *decreased libido*
- *sexual difficulties*
- *difficulty in getting pregnant*
- *infertility*

REPRODUCTIVE MALE:

- *difficulty with erections*
- *difficulty with emissions*
- *testicular pain*
- *decreased libido*
- *infertility*