



CENTER FOR HEALING NEUROLOGY

Adult Ages 18-64 Registration

Today's Date: _____

New Patient Update Account #: _____

Patient Name (Last, First, M.I.): _____

If patient has ever been known by a different name, list: _____

Home Address: _____ City, State, Zip _____

Mailing Address: _____ City, State, Zip _____

Home Phone: _____ Cell: _____

E-mail: _____ Birthdate: ____/____/____

Gender: M F Non-Binary Other Insurance Gender: M F Sex at Birth: M F

Preferred Pronouns: She/Hers He/His They/Theirs Other: _____

Register for Patient Portal? Yes No Marital Status: Single Married Other _____

Employer/School Status: Full-Time Part-Time Position: _____

Primary Care Physician: _____ Phone: _____

Referring Physician (if applic.): _____ Phone: _____

Family Information:

<input type="checkbox"/> Spouse/Domestic Partner or <input type="checkbox"/> Parent/Guardian #1		<input type="checkbox"/> Parent/Guardian #2	
Name (Last, First):		Name (Last, First):	
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	
Address:		Address:	
Employer:	Phone:	Employer:	Phone:
Position:	How Long:	Position:	How Long:

If patient is a minor, whom do they live with? Parent/Guardian #1 Parent/Guardian #2 Both Shared custody

Insurance Information: Is the patient covered by insurance? Yes or No

	Primary Insurance	Secondary Insurance	Other Insurance
Insurance Co. Name			
Subscriber Name			
Relationship to Patient			
Subscriber Employer			
Subscr. ID# or SSN			
Group # or Claim #			
Subscriber Birthdate			
Subscriber Address			
Subscriber Phone			

Preferred Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone: _____

Medicare Patients Only Check Appropriate Box

- Supplemental Insurance is provided by patient
- Supplemental Insurance is provided by former employer

Race

- American Indian or Alaskan Native Asian Black or African American
- Native Hawaiian or Other Pacific Islander White Other: _____

Ethnicity

Hispanic or Latino? Yes No

Preferred Language: _____

Please fill out below if you're here for an on-the-job injury or injury related to an accident:

Is injury job related? <input type="checkbox"/> Yes or <input type="checkbox"/> No Date of Injury ___/___/____ Claim # _____ _____
Where did injury occur? _____ Case worker Name/Phone: _____
Briefly describe injury: _____

Emergency Contact (outside of home) First & Last Name _____

Contact's Phone _____ Contact's Relationship to patient: _____

The above information in this two-page Patient Registration Form is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made.

IF INSURANCE CARD(S) ARE NOT PROVIDED AT THE TIME OF YOUR VISIT, YOU MAY BE BILLED PRIVATELY OR YOUR APPOINTMENT MAY BE RESCHEDULED.

Signature: _____ Date: ___/___/_____



Wellness
Questionnaire
for adults 18 to 64

We appreciate you taking the time to complete this questionnaire. It can help you and your health care team to make decisions about your health care needs. **Center for Healing Neurology values your privacy. We will keep all your answers confidential.** If you don't want to answer a question, feel free to leave it blank.

First Name: _____ Last Name: _____

Current or usual occupation: _____

Who are the people living with you? (include names, ages, relationships)

--

Are you allergic to any medications or foods? Yes No

If YES, please list:

Patient has Allergies to:	Reaction:

Are you currently taking any medications or supplements? Yes No

If YES, please list:

Medication/Supplement	Dosage	When is it taken?

How would you describe your general health?

- Excellent Very Good Good Fair Poor

On average, how many **days** per week do you do moderate to strenuous exercise, like a brisk walk or jog?

- 0 1 2 3 4 5 6 7 Don't know

On average, how many **minutes** do you exercise at this level each day? _____

Have you ever:

- Passed out while exercising? Yes No
 Gotten dizzy or had headaches while exercising? Yes No
 Been knocked out? Yes No

Adult Intake Form (continued)

Patient Last Name: _____

Date: _____

- Had a significant joint or bone problem? Yes No
 - Had a serious injury? Yes No
 - Can you run twice around a ¼ mile track without stopping? Yes No
-

- Do you eat fruits and vegetables every day? Yes No
 - Do you eat or drink dairy products? Yes No
 - Are you a vegetarian? Yes No
 - Do you have any questions or concerns about your eating habits Yes No
-

- During the past 2 years, have you, or has anyone in your family, had any major good or bad changes?
 Yes No If YES, please explain: _____
- Do you have any concerns about your body or weight? Yes No
 - Do you ever eat in secret or feel guilty about eating? Yes No
 - Do you ever make yourself throw up? Yes No
-

- Over the last 2 weeks, how often have you been bothered by little or no interest or pleasure in doing things?
 Not at all Several days More than half the days Most days
- Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?
 Not at all Several days More than half the days Most days
-

- How often did you have one drink containing alcohol in the last year?
 Never Monthly or less 2 to 4 times a month
 2 to 3 times a week 4 or more times a week
- How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?
 I don't drink alcohol 1 or 2 3 or 4 5 or 6 7 to 9 10 or more
- How often did you have 6 drinks or more on one occasion in the last year?
 Never Less than monthly Monthly Weekly Daily or almost daily
-

Have you ever used tobacco? Yes No

For menstruating individuals:

If you're still menstruating, when was your last period (date): _____
 Had hysterectomy Menopause On contraception that prevents periods

For individuals after menopause:

Are you taking a daily supplement that has both vitamin D and calcium? Yes No



CENTER FOR
HEALING
NEUROLOGY

Medical,
Surgical and Family
History Questionnaire

We appreciate you taking the time to complete this questionnaire. It can help you and your health care team to make decisions about your health care needs. **Center for Healing Neurology values your privacy. We will keep all your answers confidential.** If you don't want to answer a question, feel free to leave it blank.

First Name: _____ Last Name: _____

Date of Birth: ___ / ___ / _____ (Mo/Day/Year) Age: _____

Medical and Surgical History

Please list any major illnesses, injuries, or conditions that were treated outside of Center for Healing Neurology (CHN) that you haven't told us about in the past. None

Please list any major surgeries performed that you haven't told us about in the past. List each on and the approximate year. None

Family History (those related to you by blood)

Did any of the following family members develop heart disease?

Check all that apply.

Before age 55: father, brother, son None before age 55 Don't know

Before age 60: mother, sister, daughter None before age 60 Don't know

Does/did anyone in your family have any of the following disorders? This includes grandparents, uncles, aunts, parents, siblings, cousins, and children.

	Headache	Seizures	Dementia	Stroke	Aneurysm	Heart Disease
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cousin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>