CENTER FOR HEALING NEUROLOGY

Adult 65+/Medicare 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:

❒ Spouse/Domestic Partner or ❒ Parent/Guardian #1 Name (Last, First): ❒ M ❒ F ❒Other _____ Address: Employer: Phone: Position: How Long:	❒ Parent/Guardian #2 Name (Last, First): ❒ M ❒ F ❒Other _____ Address: Employer: Phone: Position: How Long:

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			

Patient Last Name:_____
Date: _____

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? ❒ Yes or ❒ 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: _____/_____/_____

Patient Last Name:_____
Date: _____

CENTER FOR HEALING NEUROLOGY

Wellness Questionnaire
for adults on Medicare or 65+

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: _____
Retired? ❒ Yes ❒ No If yes, retirement date: _____

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

Please list current providers regularly involved in your medical care.

Do you use medical equipment or prescribed supplies at home? For example oxygen, CPAP machine, wheelchair, walker, cane, incontinence supplies, ostomy supplies and others?
❒ **Yes** ❒ No

_____

How would you describe your general health?
❒ Excellent ❒ Very Good ❒ Good ❒ **Fair** ❒ **Poor**

_____

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?

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

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

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

Do you eat fruits and vegetables every day? ❒ Yes ❒ **No**
Do you eat 2 or more meals every day? ❒ Yes ❒ **No**

In the past year, have you had any major changes in your life, good or bad?
❒ **Yes** ❒ No
If YES, explain:_____

Over the last 2 weeks, how often have you been bothered by the following problems?
Feeling anxious, nervous, or on the edge?
❒ Not at all ❒ Several Days ❒ **More than half the days** ❒ **Nearly every day**

Not being able to control or stop worrying?
❒ Not at all ❒ Several Days ❒ **More than half the days** ❒ **Nearly every day**

Patient Last Name:_____

Date: _____

Over the last 12 months, how often have you felt angry?

❒ Never ❒ Rarely ❒ Sometimes ❒ **Often** ❒ **Always**

How often to you get the social and emotional support you need?

❒ Always ❒ Often ❒ Sometimes ❒ **Rarely** ❒ **Never**

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**

Have you fallen 2 or more times in the past 12 months? ❒ **Yes** ❒ No

Are you her today because of a fall? ❒ **Yes** ❒ No

Do you have any problems with walking or balance? ❒ **Yes** ❒ No

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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

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Have you ever used tobacco? ❒ **Yes** ❒ No

Do you often ask people to repeat what they've said? Or do you act as if you did hear so you don't have to ask for repeats? ❒ **Yes** ❒ No

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Do you or does anyone in your family notice that you are having memory problems that interfere with your life? ❒ **Yes** ❒ No

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Is urination or leaking urine a problem for you? ❒ **Yes** ❒ No

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How many days a week does pain or fatigue keep you from doing things you like to do?
❒ 0 ❒ 1-2 days each week ❒ **3-4 days each week** ❒ **5 or more days each week**

Do you have a signed Living Will? ❒ Yes ❒ No

Do you have an up-to-date Durable Power of Attorney for health care?
❒ Yes ❒ No ❒ Don't Know

Patient Last Name:_____

Date: _____

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

Patient Last Name:_____

Date: _____

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	❒	❒	❒	❒	❒	❒
Mother	❒	❒	❒	❒	❒	❒
Brother	❒	❒	❒	❒	❒	❒
Sister	❒	❒	❒	❒	❒	❒
Son	❒	❒	❒	❒	❒	❒
Daughter	❒	❒	❒	❒	❒	❒
Cousin	❒	❒	❒	❒	❒	❒
Paternal grandfather	❒	❒	❒	❒	❒	❒
Paternal grandmother	❒	❒	❒	❒	❒	❒
Maternal grandfather	❒	❒	❒	❒	❒	❒
Maternal grandmother	❒	❒	❒	❒	❒	❒
Paternal uncle	❒	❒	❒	❒	❒	❒
Paternal aunt	❒	❒	❒	❒	❒	❒
Maternal uncle	❒	❒	❒	❒	❒	❒
Maternal aunt	❒	❒	❒	❒	❒	❒