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:

❒ Spouse/Domestic Partner or ❒ Parent/Guardian #1	❒ Parent/Guardian #2
Name (Last, First):	Name (Last, First):
❒ M ❒ F ❒Other _____	❒ M ❒ F ❒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: This information may be needed for lab, imaging, and other referrals.

	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			

Adult Intake Form (continued) Patient Last Name:_____

Date: _____

Preferred Pharmacy:_____ Pharmacy Location: _____

Pharmacy Phone: _____

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 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

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

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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

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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

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

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	❒	❒	❒	❒	❒	❒