MultiCare Medical

701 Pinnacle Drive
Suite #105
(72nd & Cornhusker)

Patient Number (Office Use):_____

How were you referred to our office? _____Today's Date_____

Personal Information

Patient Name (Last, First, Middle)_____

Birth date:_____Age:_____ Gender: Male ☐ Female ☐

Address:_____City:_____State:_____Zip:_____

Home Ph:_____Mobile Ph:_____Work Ph:_____

Email:_____SS #:_____May we contact you at work? Yes ☐ No ☐

Driver's License #:_____Preferred Method of Contact? Home☐ Work☐ Cell☐ Email☐

Occupation:_____Employer:_____Address:_____

Emergency Contact (Name):_____Ph:_____Relationship:_____

Marital Status: M S D W Name of spouse/significant other:_____# of Children:_____

Race:_____Ethnicity:_____Preferred Language:_____

Payment/Insurance Information

Payment Type: Cash/Check/CC☐ Medicare☐ Medicaid☐ Insurance☐ Personal Injury/Auto☐ WC ☐

Primary Insurance:_____Policy #:_____

Secondary Insurance:_____Policy#:_____

Insured's Name (Last, First, Middle):_____

Birth Date (MM/DD/YYYY):_____Who carries this policy? Self☐ Spouse☐ Parent☐

Insured's Employer:_____Address:_____

City:_____State:_____Zip:_____Employer's Ph:_____

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. Inital_____

Health History

Chief Complaint:_____When did you first notice?_____
Where do you notice the pain more? Left☐ Right☐ Middle☐ Both sides☐
Do you know what caused this? Accident☐ Work☐ Auto☐ Unknown☐ Other_____
Accident Date:_____ Did you report this accident? Yes☐ No☐
Is it getting: Better☐ Worse☐ No Change☐ Have you had this condition before? Yes☐ No☐
What makes it worse?_____What makes it better?_____
Describe the symptoms: Numbness☐ Tingling☐ Stiffness☐ Dull☐ Aching☐ Cramps☐ Nagging☐ Sharp☐
Burning☐ Shooting☐ Throbbing☐ Stabbing☐ Other☐_____
Does radiate to other areas? Yes☐ No☐ If yes, where?_____
Rate the severity of pain (0-10, 10=severe) at its worst_____What time of day is worst?_____
How would you describe the frequency of symptoms? Constant☐ Frequent☐ Intermittent☐ Occasional☐
Prior Interventions you have tried? Prescription Meds☐ OTC Drugs☐ Surgery☐ Acupuncture☐ Chiropractic☐
PT☐ Massage☐ Ice☐ Heat☐ Homeopathic Remedies☐ Other☐ _____
Did you have a/an Xray☐ MRI☐ CT☐ Other☐_____
Isthereanythingelseweshouldknowaboutthiscomplaint?_____
_____
How does your current condition interfere with your:
Work or career?_____
Recreational activities?_____
Householdresponsibilities?_____
Personal relationships?_____

Past Medical History

Have you ever had the following (mark "yes" or "no" / leave blank if uncertain).

Measles	Yes☐ No☐	Epilepsy	Yes☐ No☐	Hemorrhoids	Yes☐ No☐
Mumps	Yes☐ No☐	Migraine Headaches	Yes☐ No☐	Asthma	Yes☐ No☐
Chicken Pox	Yes☐ No☐	Tuberculosis	Yes☐ No☐	Hives of Eczema	Yes☐ No☐
Whooping Cough	Yes☐ No☐	Diabetes	Yes☐ No☐	AIDS / HIV	Yes☐ No☐
Scalet Fever	Yes☐ No☐	Cancer	Yes☐ No☐	Infectious Mono	Yes☐ No☐
Diphtheria	Yes☐ No☐	Polio	Yes☐ No☐	Bronchitits	Yes☐ No☐
Small Pox	Yes☐ No☐	Glaucoma	Yes☐ No☐	Mitral Valve Prolapse	Yes☐ No☐
Pneumonia	Yes☐ No☐	Hernia	Yes☐ No☐	Stroke	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Blood Transfusion	Yes☐ No☐	Hepatitis	Yes☐ No☐
Arthritis	Yes☐ No☐	Plasma Transfusion	Yes☐ No☐	Ulcer	Yes☐ No☐
Venereal Disease	Yes☐ No☐	Back Trouble	Yes☐ No☐	Kidney Disease	Yes☐ No☐
Anemia	Yes☐ No☐	High Blood Pressure	Yes☐ No☐	Thyroid Disease	Yes☐ No☐
Bladder Infection	Yes☐ No☐	Low Blood Pressure	Yes☐ No☐	Bleeding Tendency	Yes☐ No☐

Previous Hospitalizations / Surgeries / Serious Illnesses - (Please List When and Where)

_____
_____
_____

Medications (include non-prescription)

_____
_____

Have you ever taken Fen-Phen Redux? Yes☐ No☐
Are you taking any medication for acid indigestion (prescription or OTC)? Yes☐ No☐_____

Patient Social History

Use of Alcohol Never☐ Rarely☐ Moderate☐ Daily☐
Use of Tobacco Never☐ Rarely☐ Moderate☐ Daily☐
Use of Drugs Never☐ Rarely☐ Moderate☐ Daily☐ Type/Frequency_____
Excessive Exposure (home/work) to: Fumes☐ Dust☐ Solvents☐ Airborne Particles☐ Noise☐
Clinician Signature:_____Date Reviewed:_____

Family Medical History

Relative	Age	Disease	If deceased, Cause of Death
Father			
Mother			
Siblings			
Siblings			
Spouse			
Children			
Children			

Review of Systems

Indicate symptoms experienced in the past 1-2 mo. (1-Never, 2-Rarely, 3-Occasionally, 4-Frequent, 5-Constant)

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore Throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Ear Ache/Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

(Females) Currently Pregnant? Yes☐ No☐

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Shoulder Blade Pain	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness/Tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling Foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

Signature of Patient, Parent or Guardian_____Date:_____

Doctor's Signature_____Date:_____