newbeginnings
wellness center and spa

New Patient Medical Intake

PATIENT INFORMATION

How did you hear about New Beginnings?

Last Name: First Name: MI: DOB: Female Male

Home Address: City: State: Zip:

Billing Address: City: State: Zip:

Phone 1:( ) Home Work Cell

Phone 2:( ) Home Work Cell

Social Security #:

Emergency contact: Phone: ( ) Relationship:

Email Address: Marital Status: Single Married Widow Divorced

Employer: Occupation:

INSURANCE INFORMATION: TO BE USED FOR LABS IF DESIRED

Primary Insurance: Policy Holder:

DOB: SS#: Policy#: Group#:

Secondary Insurance: Policy Holder:

DOB: SS#: Policy#: Group#:

Name of Spouse or Parent (if a minor):

Spouse's/Parent's Employer: Telephone#:

HEALTH ASSESSMENT: TO BE FILLED OUT COMPLETELY WITH ATTENTION TO FAMILY HISTORY

What is most important to you about your medical care? (e.g. communication, prevention, wellness)

What specific concerns would you like to address with your new clinician?

MEDICATIONS & ALLERGIES

Please list all your current medications and allergies (including vitamins and supplements)

	Medication	Dose	Frequency	Taken for	Prescribed by
1.					
2.					
3.					
4.					
5.					

PLEASE LIST ANY ADDITIONAL MEDICATIONS OR SUPPLEMENTS ON THE BACK OF THIS PAGE.

Allergies to medications and other items:

1. Reaction:

2. Reaction:

Preferred Pharmacy: Phone:

Address:

PERSONAL MEDICAL HISTORY

Have you ever had any problems with the following: (if yes, please explain)

Alcohol or substance abuse:	Metabolism (diabetes, thyroid, etc):
Blood:	Muscle, joint, bones:
Cancer:	Nerves and brain:
Digestion:	Skin and hair:
Ear, nose, throat, eyes:	Sleep:
ER Visits: Type: Date:	Social, mental or emotional health:
Heart or blood vessels:	Kidneys or bladder:

Lungs:	Other:
Surgeries and their date:	

FAMILY MEDICAL HISTORY

Please indicate any family members who have had the following:

Alcohol abuse:	Bleeding disorders:	Deafness:
Arthritis:	Breast cancer:	Dementia:
Bipolar Disorder:	Cystic Fibrosis:	Glaucoma:
Heart Attack:	Lymphoma/Leukemia:	Schizophrenia:
High Blood Pressure:	Osteoporosis:	Sickle cell anemia:
High blood cholesterol:	Obesity:	Skin cancer:
HIV:	Parkinson's disease:	Stroke:
Inherited anemias:	Prostate cancer:	Substance Abuse:
Asthma:	Cancer of an unknown cause:	Thyroid:
Autism:	Colon Cancer:	Depression:
Crohn's disease:	Diabetes	Other Cancers:

Any condition that two or more relatives have?

SOCIAL AND LIFESTYLE HISTORY

Do you use or have you used tobacco products? Yes or No

Does anyone routinely smoke in your presence? Yes or No

Do you use or have you ever used recreational drugs? Yes or No
If yes, please explain (type, how long, frequency of use, etc.):

How much caffeine (including sodas/tea) do you consume daily?

Do you have concerns about your diet? Yes or No

If yes, please explain:

How often do you exercise?

HEALTH MAINTENANCE & PREVENTION

When was the last time you:

Had a Tetanus booster:

Had a blood sugar test:

Had a cholesterol test:

Had a colon cancer screening:

Have any of the above tests been abnormal? If yes, please explain:

Women's Health

When was your last: PAP smear: Mammogram: Bone Density:

Have you ever had an abnormal result for any of the above tests? If yes, please explain:

Pregnancies (#): Births (#): Living Children(#): Miscarriages (#): Abortions (#):

Men's Health

When was your last Prostate exam and/or PSA test?

Have you ever had an abnormal prostate exam or PSA test? If yes, please explain:

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize New Beginnings Wellness Center and Spa to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day-to-day healthcare operations of New Beginnings Wellness Center and Spa.

I have also been informed of, and given the right to review and secure a copy of the New Beginnings Wellness Center and Spa Privacy Policy, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. In understand that New Beginnings Wellness Center and Spa reserves the right to change the terms of this notice from time to time and that I may contact New Beginnings Wellness Center and Spa at anytime to obtain the current copy of this notice.

I understand d that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and healthcare operations, but that New Beginnings Wellness Center and Spa is not required to agree to these requested restriction. However, if New Beginnings Wellness Center and Spa does agree then New Beginnings Wellness Center and Spa is bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time; however, any use or disclosure that occurred prior to the date I revoke is not affected.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at New Beginnings Wellness Center and Spa.

Authorization to communicate Protected Health Information – Check all that apply:

- ☐ New Beginnings Wellness Center and Spa may leave a detailed message on voicemail at my home #: (_____)_____
- ☐ New Beginnings Wellness Center and Spa may leave a detailed message on voicemail on my cell #: (_____) _____
- ☐ New Beginnings Wellness Center and Spa may speak with another person (spouse, family member) about my medical condition ___ **including** /___ **excluding** information related to mental health, sexually transmitted disease, HIV status and reproductive medicine: Name/Relation:_____ Phone #: (____) _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify New Beginnings Wellness Center and Spa should I change one or more of the telephone numbers listed above.

_____ _____

Patient Signature Date Patient Name Printed

_____ _____

Representative Name Relationship to Patient