**NEW PATIENT CONSENT AND HISTORY FORMS**

* **I acknowledge that I have read and agreed to the Confidentiality Release. You may release my information to the following individuals (other than referring physician office)**
* **I have received a copy of the office’s Notice of Privacy Practices Form or acknowledge having read them.**
* **I acknowledge and agree to The Alpiner Group Consent for Treatment.**
* **I acknowledge that it is my responsibility to notify Dr. Alpiner’s staff of dates that tests have been taken so that results may be properly followed up.**
* **I have read, understand and agree to The Alpiner Group Financial Policies as described above.**
* **I have read, understand and agree to all policies and terms of The Alpiner Group.**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guarantor or Guardian (Relationship to Patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEW PATIENT INFORMATION**

Date \_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Sex: M F

Who referred you to our office for care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The reason for today’s office visit is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chief Complaint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests have you had for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you sustain an injury or trauma? Y N Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a lawsuit pending or anticipated in this case? Y N Filing for disability? Y N

Patient treated at hospital for this condition? Y N When? Where?

Physicians you have seen for this problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approximate Date treated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History

Other medical problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries and Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Accidents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other problems: Review of Symptoms **PLEASE PUT NOTE IF YOU HAVE ANY OF THE FOLLOWING**

|  |  |  |
| --- | --- | --- |
| Head | Bladder | Psychiatric |
| Throat | Bowel  | Weight Gain |
| Chest | Fevers/Chills | Weight Loss |
| Heart | Muscles | Appetite |
| Abdomen | Bones | Blood |
| Skin  | Endocrine Glands |  |

Concussion, Head Injury, Seizures, Migraines/Headaches, Pain Syndromes, Autism/Spectrum Disorders,

Muscle Weakness, Hypotonia, Cerebral Palsy, Torticollis, Gait Disturbance, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Behavioral*** (circle all that apply)

ADD/ADHD, Depression, Anxiety, Bipolar, Personality Disorder, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has patient had any behavioral/counseling therapy previously?

Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***General Medical*** (circle all that apply)

Obesity, Asthma, Heart Disease/Congenital Heart Disease, Arthritis, Diabetes, Colic, Cancer/Oncologic

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HISTORY OF PRESENT PAIN (if applicable):**

How long has patient noticed the pain?

\_\_\_\_Days \_\_\_\_\_Weeks \_\_\_\_Months \_\_\_\_\_Years

Rate USUAL pain: **WHAT NUMBER IS YOUR PAIN**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Describe pain: **WHAT TYPE OF PAIN ARE YOU EXPERIENCING**

Burning, Tingling, Numbness, Pinprick, Stabbing, Deep-Pressure, Tightness, Spasms

Any prior injury or pain before the event above? Please describe.

Have you seen a specialist concerning this pain prior? Please indicate specialist and date if seen.



**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAIN (if applicable)**

**Has the patient had therapy or treatment related to this condition previously?**

**Physical Therapy Occupational Therapy**

**Speech Therapy Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE LIST LOCATION AND DATE OF ANY OF THE FOLLOWING;**

If yes, when and where test performed?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| X-Ray | MRI | CT | EMG | Bone Scan | Laboratory  | Other |

**IF THE PATIENT HAD A CONCUSSIVE/HEAD/BRAIN INJURY:**

Are you currently experiencing any of the following (LIST OR PUT “X” NEXT TO ANY THAT APPLY):

|  |  |  |  |
| --- | --- | --- | --- |
| Dizziness | Headaches | Nausea | Vertigo |
| Loss of Balance | Concentration Issues | Visual Disturbance | Sound/Light Sensitivity |
| Difficulty Reading | Mood Changes | Academic Struggles | Other(Please Explain) |

**PREVIOUS MEDICATIONS PRESCRIBED OVER PAST TWO YEARS**

**Name of Medication Dosage**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**FAMILY HISTORY:**

**Please list any major medical conditions that your Mother, Father, Maternal/Paternal Grandparents, Aunts, Uncles and Siblings may have**

**Relationship Diagnosis**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SOCIAL HISTORY**

Primary language spoken in home

Who lives in home with patient?

Please check if appropriate

* Tobacco/smoke use
* Tobacco/smoke exposure
* Substance abuse
* Exercise regularly
	+ If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER MEDICAL HISTORY**

Please notify this office of any prior relevant medical history. Please inform of any outside health encounters.

**PEDIATRIC PATIENTS (Adult patients do not need to complete)**

**Developmental History:**

 Not Delayed Delayed Other (explain)

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade \_\_\_\_\_\_\_\_

Attendance (circle) Good Fair Poor

Performance/Grades A B C D E

History of Learning Disability YES NO

Other activities outside of school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Safety:

* Seat belt use
* Helmet use