

HEALTH HISTORY

Welcome to our practice. As a new patient please fill out the information found below to the best of your ability. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____

Patient Name _____

DOB _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem)

Quality: _____
(Example: normal versus abnormal color, activity etc.)

Severity: _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe)

Duration: _____
(How long have you had this pain/problem? Or when did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the start of this pain/problem?)

Associated signs/symptoms _____

Modifying factors: _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better?)

Past Medical History

Have you ever had the following: (circle "no" or "yes". Leave blank if uncertain)

Measles.....no yes	Anemia.....no yes	Back trouble.....no yes	Hepatitis.....no yes
Mumps.....no yes	Bladder infections...no yes	High Blood Pressure...no yes	Ulcer.....no yes
Chickenpox.....no yes	Epilepsy.....no yes	Low Blood Pressure....no yes	Kidney Disease.....no yes
Whooping Cough...no yes	Migraines.....no yes	Hemorrhoids.....no yes	Thyroid Disease.....no yes
Scarlet Fever.....no yes	Tuberculosis.....no yes	Asthma.....no yes	Bleeding Tendencyno yes
Diphtheria.....no yes	Diabetes.....no yes	Hives or Eczema.....no yes	Date of Last Chest Xray
Smallpox.....no yes	Cancer.....no yes	AIDS or HIV +no yes	_____
Pneumonia.....no yes	Polio.....no yes	Infectious Mono.....no yes	Any other Disease- please list:
Rheumatic Fever...no yes	Glaucoma.....no yes	Bronchitis.....no yes	_____
Heart Disease.....no yes	Hernia.....no yes	Mitral Valve Prolapse...no yes	_____
Arthritis.....no yes	Blood or Plasma	Stroke.....no yes	_____
Venereal Disease..no yes	Transfusions.....no yes		_____

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

Medications: (include non-prescriptions and Homeopathy)

Patient Social History:

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current packs/day _____

Use of drugs: Never _____ Type/Frequency _____

Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Air-borne Particles _____ Noise _____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
M Grand Mother	_____	_____	_____
M Grand Father	_____	_____	_____
F Grand Mother	_____	_____	_____
F Grand Father	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms:

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

Eyes:

Eye disease or injury..... No Yes
 Wear glasses/contacts..... No Yes
 Blurred or double vision..... No Yes

Ears/Nose/Mouth/Throat:

Hearing loss or ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problem or rhinitis... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Bad breath or bad taste..... No Yes
 Sore throat or voice change..... No Yes
 Swollen glands in neck..... No Yes

Genitourinary:

Frequent urination..... No Yes
 Burning or painful urination... No Yes
 Blood in urine..... No Yes
 Change in force of strain when urinating..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
 Male -testicle pain..... No Yes
 Female-pain w/period..... No Yes
 Female-irregular periods..... No Yes
 Female-vaginal discharge..... No Yes
 Female-date/last pap smear.... _____
 Female #/miscarriages..... _____
 Female #/pregnancies..... _____

Musculoskeletal:

Joint pain..... No Yes
 Joint stiffness or swelling..... No Yes
 Weakness of muscles/joints.... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Difficulty/walking..... No Yes

Psychiatric:

Memory loss or confusion.... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

Endocrine:

Glandular or hormone problem..... No Yes
 Excessive thirst or urination.. No Yes
 Heat or cold intolerance..... No Yes
 Skin becoming dryer..... No Yes
 Change in hat or glove size... No Yes

Hematological:

Slow to heal/cuts..... No Yes
 Bleeding or bruising tendency..... No Yes
 Anemia No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

Cardiovascular:

Cold extremities.....No Yes
Heart trouble..... No Yes
Chest pain or angina pectoris.....No Yes
Palpitation..... No Yes
Shortness of breath w/walking..... No Yes
or lying flat..... No Yes
Swelling of feet, ankles or hands.. No Yes

Respiratory

Chronic or frequent coughs..... No Yes
Spitting up blood..... No Yes
Shortness of breath..... No Yes
Wheezing..... No Yes

Gastrointestinal

Loss of appetite..... No Yes
Change in bowel movements.....No Yes
Nausea or vomiting..... No Yes
Frequent diarrhea..... No Yes
Painful bowel movements..... No Yes
or constipation..... No Yes
Rectal bleeding.....No Yes
or blood in stool..... No Yes
Abdominal pain.....No Yes

Integumentary (skin/breast)

Rash or itching.....No Yes
Change in skin color.....No Yes
Change in hair or nails.....No Yes
Varicose veins.....No Yes
Breast pain.....No Yes
Breast lump.....No Yes
Breast discharge.....No Yes

Neurological

Convulsions or seizures.....No Yes
Numbness/tingling sensations.....No Yes
Tremors.....No Yes
Paralysis.....No Yes
Head injury.....No Yes
Frequent/recurring headaches.....No Yes
Light headed or dizzy.....No Yes

Allergic/Immunologic:

*History of skin
reaction or other adverse
reactions to:*

Penicillin or other antibiotics..No Yes
Morphine/Demerol/Codeine
or other Narcotics.....No Yes
Novocain or anesthetics.....No Yes
Aspirin or other
pain remedies.....No Yes
Tetanus antitoxin
or other serums.....No Yes
Iodine/Methiolate or
other antiseptic.....No Yes
Other drugs/medications.....No Yes

Known food allergies _____

Environmental allergies _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient/ Parent/ Guardian

Date

Doctor's Notes/Review:

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly we need the following information.
Please print. All information will be confidential.

Patient Name _____ Date: _____
Address _____ City _____ State _____ Zip _____
SSN# _____ Male Female Birthday: _____ E-Mail _____
Home phone # _____ Work phone # _____ Cell phone # _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient/Parent's Employer: _____ Work Phone: _____
Business Address: _____
Spouse/Parent's Name _____ Employer _____ Work Ph# _____
Person to contact in case of emergency _____ Phone # _____
Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient _____
Address: _____
Driver's License #: _____ Date of Birth: _____ Home Ph: _____
Employer: _____ Work Ph: _____
Is this person currently a patient at our office? Yes No

Insurance Information

Name of Insured: (same?) _____ Relationship to patient _____
Date of Birth: _____ SSN # _____ Date Employed: _____
Name of Employer: _____ Work Ph: _____
Address of Employer: _____
Insurance Company: _____ Group # _____ Union or local # _____
Ins. Co. Address: _____
How much is your deductible? _____ How much have you used? _____

Do you have any additional insurance ? Yes No If yes, complete the following:

Name of Insured: (same?) _____ Relationship to patient _____
Birthdate: _____ SSN # _____ Date Employed _____
Name/Address of Employer: _____
Insurance Company: _____ Group # _____ Union or local # _____
Ins. Co. Address: _____
How much is your deductible? _____ How much have you used? _____

X _____

Signature of Patient

_____ Date

PHYSICIANS FOR ALTERNATIVE MEDICINE, P.C.

-
107 MONMOUTH ROAD - SUITE 104
WEST LONG BRANCH, NJ 07764

Dr. Judith Volpe, M.D.
Dr. John Salerno, Ph.D.

-
Tel: (732) 542-2638
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All New Patients:

Please bring in any laboratory tests that you have had in the last 3 to 6 months for your first office visit if available. It would be very useful to our clinicians.

Thank you in advance.

Physicians for Alternative Medicine

PHYSICIANS FOR ALTERNATIVE MEDICINE

GENERAL INFORMATION REGARDING LABORATORY TESTS

OUR FACILITY DOES NOT PERFORM OR BILL FOR DIAGNOSTIC LABORATORY TESTING. BILLS FOR THESE TESTS WILL BE SENT TO YOU OR YOUR INSURANCE CARRIER FROM THE LABORATORY, WHICH PERFORMED THE TEST (S). IN SOME INSTANCES OUR STAFF MAY DRAW OR COLLECT THE APPROPRIATE SAMPLE AND FORWARD IT TO THE LAB FOR PROCESSING. IN THOSE CASES A SMALL DRAWING OR HANDLING FEE MAY APPLY.

THE NATURE OF THE LABORATORY TESTS WHICH MAY BE ORDERED FOR YOU ARE CUSTOMIZED, AS THEY DEPEND ON THE SPECIFIC MEDICAL PROFILE THE DOCTOR REQUIRES TO EVALUATE AND TREAT YOUR CONDITION. ALTHOUGH WE PROVIDE THE NECESSARY CODES, **WE CAN NOT BE CERTAIN THAT YOUR INSURANCE PLAN WILL COVER ALL NECESSARY TESTS.** PLEASE CONTACT YOUR INSURANCE COMPANY DIRECTLY FOR VERIFICATION OF LABORATORY COVERAGE.

PLEASE NOTE:

THE DOCTOR MAY ORDER SPECIALIZED TESTING THAT REQUIRES A SPECIMEN TO BE SENT TO AN OUT OF NETWORK LABORATORY. THESE SPECIALTY LABORATORYS REQUIRE PAYMENT IN ADVANCE. FEES VARY GREATLY. (PARTIAL REINBURSEMENT MAY BE AVAILABLE THROUGH YOUR INSURANCE CARRIER).

PHYSICIANS FOR ALTERNATIVE MEDICINE

This is to certify that I _____ (Patient/Guardian)

Request that my medical information only be released to:

FAMILY

MEDICAL OFFICES/LABORATORIES

OR

I do not wish to have any of my health-related information released to any one other than myself

I GIVE PERMISSION TO LEAVE MESSAGES PERTAINING TO BLOOD WORK RESULTS, OUTSIDE TESTING, APPOINTMENT REMINDERS, ETC. EITHER ON MY ANSWERING MACHINE OR WITH A FAMILY MEMBER WHO ANSWERS MY HOME TELEPHONE

OR

IF I AM UNABLE TO BE REACHED BY PHONE, NO MESSAGE PERTAINING TO MYSELF IS TO BE LEFT ON MY HOME ANSWERING MACHINE

Signature _____ (Patient/Guardian)

Date _____

ANY CHANGES OF PATIENT RELEASE INFORMATION MUST BE GIVEN IN WRITING,,,VERBAL REQUESTS FOR CHANGES WILL NOT BE HONORED

Phone (732) 542-2638 Fax (732) 542-2620

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PHYSICIANS SERVICES

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ASSIGNMENT OF BENEFITS FORM

Patient Name _____

I IRREVOCABLY ASSIGN TO: PHYSICIAN SERVICES ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY: PHYSICIAN SERVICES. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY PHYSICIAN SERVICES TO BE RELEASED TO PHYSICIAN SERVICES. I IRREVOCABLY AUTHORIZE PHYSICIAN SERVICES TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO PHYSICIAN SERVICES. I IRREVOCABLY AUTHORIZE PHYSICIAN SERVICES TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.
THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT SIGNATURE _____

DATE _____

