OASIS Wellness Center

Patient Intake Form

Account # _____

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____ **Birthdate**:_____/_____/_____

Gender: □ Male □ Female □ Unspecified **Age**: _____

Address:_____**City**:_____**State:**_____**Zip:**_____

Primary Phone:_____ **Cell Phone**:_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Email □ Text Message

Patient Employer/School:_____ **Occupation**:_____

Choose One: □ Married □ Separated □ Widowed □ Divorced □ Single □ Partnered for _____ years.

Spouse's Name: _____ **Spouse's Birthdate:** _____/_____/_____

Who may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT

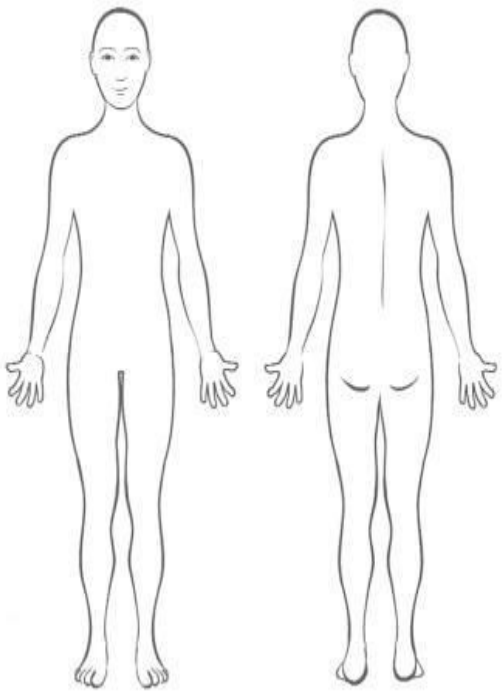
Name: _____

Relationship: _____

Phone Number: _____

REASON FOR VISIT

What is the reason for your visit today? _____



When did this complaint begin? _____/_____/_____

Is the condition getting worse?: □ Yes □ No □ Unknown

*Mark an X on the picture where the pain is located.

Rate the severity of the pain from 0-10: _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □Shooting □ Burning □ Tingling □ Cramping □ Stiffness □ Swelling □ Other: _____

How often do you have this pain?

_____

Is this pain: □ Constant □ Come and go

Does the pain interfere with: □ School □ Sleep □ Daily Routine □ Other Activities: _____

Activities that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

HEALTH HISTORY

Have you had any: □ Falls □ Head Injuries □ Broken Bones □ Dislocations □ Surgeries:

_____

Are you currently taking any medications? □ Yes □ No

Is there a chance you could be pregnant? □ Yes □ No Due Date: _____

Please check the box if you have had **ANY** of the following:			
□ AIDS/HIV	□ Fractures	□ Mumps	□ Tumors, Growth
□ Alcoholism	□ Glaucoma	□ Osteoporosis	□ Typhoid Fever
□ Allergy/Shots	□ Goiter	□ Pacemaker	□ Ulcers
□ Anemia	□ Gonorrhea	□ Parkinson's Disease	□ Vaginal Infections
□ Anorexia	□ Gout	□ Pinched Nerve	□ Whooping Cough
□ Appendicitis	□ Heart Disease	□ Pneumonia	□ Other: _____
□ Arthritis	□ Hepatitis	□ Polio	
□ Asthma	□ Hernia	□ Prostate Problem	
□ Bleeding Disorders	□ Herniated Disk	□ Prosthesis	
□ Breast Lump	□ Herpes	□ Psychiatric Care	
□ Bronchitis	□ High Blood Pressure	□ Rheumatoid Arthritis	
□ Bulimia	□ High Cholesterol	□ Rheumatic Fever	
□ Cancer	□ Kidney Disease	□ Scarlet Fever	
□ Cataracts	□ Liver Disease	□ Sexually Transmitted Disease	
□ Chemical Dependency	□ Measles	□ Stroke	
□ Chicken Pox	□ Migraine Headache	□ Suicide Attempt	
□ Diabetes	□ Miscarriage	□ Thyroid Problems	
□ Emphysema	□ Mononucleosis	□ Tonsillitis	
□ Epilepsy	□ Multiple Sclerosis	□ Tuberculosis	

Exercise: □ None
□ Moderate
□ Daily
□ Heavy

Work Activity: □ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits: □ Smoking Packs/Day: _____
□ Alcohol Drinks/Week: _____
□ Coffee/Caffeine Drinks Cups/Day: _____
□ High Stress Level Reason: _____

ASSIGNMENT AND RELEASE

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with _____ and assign directly to Dr. Thomas Baader all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian or Representative **Relationship to Patient**