

Northeast College of Health Sciences Patient Registration

Seneca Falls Health Center – Levittown Health Center- Depew Health Center- Campus Health Center

Welcome to our Health Center! Your Health History is important to us. Please fill out this form COMPLETELY.					
Today's Date:					
Patient Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Prof. <input type="checkbox"/> Rev.					
Last Name					
First Name		Middle Initial			
Address					
City		State		Zip	
Primary Phone ()			Mobile Phone ()		
Email:					
Date of Birth: / /		Age	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
Marital Status: (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other					
Emergency Contact:				Phone: ()	
Primary Care Provider:				Phone: ()	
Primary Care Provider Address:					
<input type="checkbox"/> Please do not share the results of this visit with this provider					
Race: Please Check One					
<input type="checkbox"/> White		<input type="checkbox"/> Black/African American		<input type="checkbox"/> American Indian/Alaskan Native	
<input type="checkbox"/> Native Hawaiian/other Pacific Island		<input type="checkbox"/> Other		<input type="checkbox"/> Choose not to Specify	
Ethnicity: Please Check One					
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> Choose not to Specify	
Preferred Language: Please Check One					
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Chinese	
<input type="checkbox"/> Other		<input type="checkbox"/> French		<input type="checkbox"/> Tagalog	
				<input type="checkbox"/> American Sign Language	
				<input type="checkbox"/> Choose not to Specify	
Are you the patient, or are you completing this for the patient? <input type="checkbox"/> I am the patient. <input type="checkbox"/> I am completing this for the patient. Is the patient a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are completing this form for the patient, please enter your name:					
Employment Status: Please Check One					
<input type="checkbox"/> Employed Full Time		<input type="checkbox"/> Employed Part-time		<input type="checkbox"/> FT Student	
<input type="checkbox"/> Retired		<input type="checkbox"/> Self-Employed		<input type="checkbox"/> PT Student	
<input type="checkbox"/> Other					
Employer Name		Address			
City		State		ZIP	
Employer Phone: ()			Position/Occupation		
Please Continue on the Reverse					

Patient Name:	
Insurance Information	
Subscriber's Name	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	
Is Patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Subscriber's Name:	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	

Please tell us how you heard about us:
<input type="checkbox"/> Physician Referral (Please indicate Name)
<input type="checkbox"/> Personal Referral (Please indicate Name)
<input type="checkbox"/> Phone Book <input type="checkbox"/> Internet Search <input type="checkbox"/> Other (Please Specify)



Please review the following statements and sign on the last line indicating your agreement:

Payment Verification: 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

General Verification: To the best of my ability, the information I have supplied today is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Patient Signature:	Date:
---------------------------	--------------

Please Continue to the Next Page

New Patient Information					Date:					
Patient Name:										
CURRENT MEDICATIONS: Please list all prescriptions, over-the-counter medicines and supplements) including frequency and dosage (if known). If there are NO current medications, check here <input type="checkbox"/>										
1.			2.			3.			4.	
5.			6.			7.			8.	
Please list any ALLERGIES you have to medications. If NO known allergies, check here <input type="checkbox"/>										
1.			2.			3.			4.	
Do you use tobacco of any type? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Tobacco User <input type="checkbox"/> Never Used Tobacco										
If Yes, how often do you use tobacco? <input type="checkbox"/> Current every day user <input type="checkbox"/> Current sometimes user										
If you are a tobacco user, what is your interest in quitting on a scale where 0 is "No Interest" and 10 is "Very Interested"?										
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Do you presently have a diagnosis of Hypertension?					<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you presently have a diagnosis of Diabetes? <input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes" to Diabetes, what kind?					<input type="checkbox"/> Type I <input type="checkbox"/> Type II					
If "Yes" to Diabetes, do you know your A1C level?					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure					
Comments regarding your Diabetes diagnosis:										
YOUR SYMPTOMS TODAY										
Please describe your symptoms:										
When did your symptoms start? Month			Day			Year				
How did your symptoms begin?										
Please indicate the location and severity of your symptoms on the Pain Diagram given to you today										
How often do you experience your symptoms?										
Do your symptoms affect other areas of your body? To what extent does the pain radiate, shoot or travel?										
What makes your pain better or worse? (Certain movements, activities, positions, etc.)										
Better:										
Worse:										
What time of day do you experience your symptoms? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night										
Prior Interventions: What have you done to relieve the symptoms? Please Check all that apply										
<input type="checkbox"/> Prescription Medicine			<input type="checkbox"/> Acupuncture			<input type="checkbox"/> Over the Counter Medication			<input type="checkbox"/> Ice	
<input type="checkbox"/> Homeopathic Remedies			<input type="checkbox"/> Chiropractic			<input type="checkbox"/> Physical Therapy			<input type="checkbox"/> Heat	
<input type="checkbox"/> Massage			<input type="checkbox"/> Other							
Please Continue on the Reverse										

New Patient Information				Date:			
Patient Name:							
Is your condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident or Injury:							
Have you reported this accident to:							
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Workers' Comp. <input type="checkbox"/> Other <input type="checkbox"/> Not Reported							
Is there anything else we should know about your condition?							
Please check the boxes if you HAVE or HAD any of the listed conditions							
Musculoskeletal		Cardiovascular		Endocrine		Respiratory	
<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Thyroid Issues	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	Apnea
<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	Frequent Infection	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Angina	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Hip Disorders	<input type="checkbox"/>	Excessive Bruising	<input type="checkbox"/>	Low Energy	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Knee Injuries	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other
<input type="checkbox"/>	Elbow/Wrist Pain					<input type="checkbox"/>	
<input type="checkbox"/>	TMJ Issues	Digestive		Genitourinary		Integumentary	
<input type="checkbox"/>	Foot/ankle Pain	<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues
<input type="checkbox"/>	Poor Posture	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Skin Cancer
<input type="checkbox"/>	Shoulder Problems	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Other	<input type="checkbox"/>	Food sensitivities	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	Eczema
Neurological		<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Prostate Issues	<input type="checkbox"/>	Acne
<input type="checkbox"/>	No Issues	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	Swollen Glands
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	PMS Symptoms	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other
<input type="checkbox"/>	Headache	Sensory		Constitutional			
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	No Issues	<input type="checkbox"/>	No Issues		
<input type="checkbox"/>	Pins and Needles	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Fainting		
<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Ringling in Ears	<input type="checkbox"/>	Low Libido		
<input type="checkbox"/>	Other	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Poor Appetite		
		<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	Fatigue		
		<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	Erectile Dysfunction		
		<input type="checkbox"/>	Chronic Ear Infection	<input type="checkbox"/>	Weakness		
		<input type="checkbox"/>	Other	<input type="checkbox"/>	Other		
Please explain any items you checked above:							
ITEM		EXPLANATION					

Please Continue to the Next Page

New Patient Information						Date:				
Patient Name:										
Are there any past or current medical conditions you have not told us about?										
Please list date(s) and reason(s) for any hospitalizations:										
Date	Reason				Date	Reason				
Please list any surgical procedures you have had:										
Date	Procedure				Date	Procedure				
Please list any other injuries not described above:										
Date	Injury				Date	Injury				
Family History										
Relative	Health Condition or Illness									
Mother										
Father										
Brother(s)										
Sister(s)										
Son(s)										
Daughter(s)										
Other										
Stress Information										
On a scale of 0 to 10, where 0 means you have NO stress and 10 means a LOT OF STRESS, please indicate your PHYSICAL stress level:										
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
On a scale of 0 to 10, where 0 means you have NO stress and 10 means a lot of stress, please indicate your EMOTIONAL stress level:										
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
What are the major stressors in your life:										

Please Continue on the Reverse

New Patient Information						Date:				
Patient Name:										
Consumption, Sleeping , and Exercise Information										
How much alcohol do you consume?						Frequency?				
How many cups of coffee do you drink daily?										
How much soda pop do you consume daily?										
How much water do you drink daily?										
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Please rate your eating habits where 0 means your eating habits are UNHEALTHY and 10 means your eating habits are HEALTHY:										
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
What are your typical eating habits:										
<input type="checkbox"/> Skip Breakfast			<input type="checkbox"/> 2 Meals per Day			<input type="checkbox"/> 3 Meals per Day			<input type="checkbox"/> Snacking Between Meals	
On average, how many hours do you sleep at night?										
What is your preferred sleeping position?										
On a regular basis, how much do you exercise?										
What would be the most significant thing you could do to improve your health?										
What additional health goals do you have?										

Patient Signature:

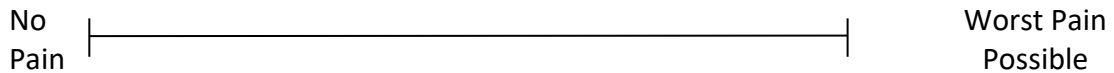
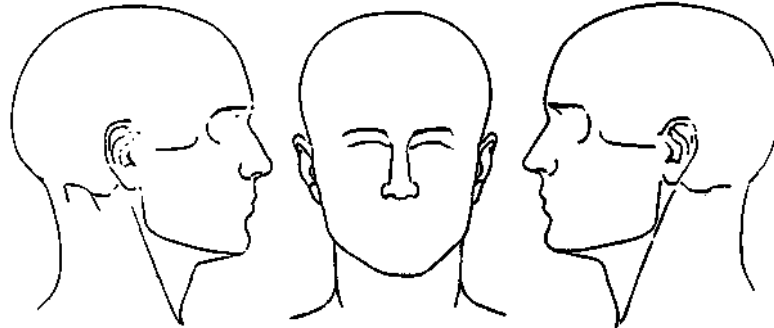
Pain Diagram

Patient's Name: _____

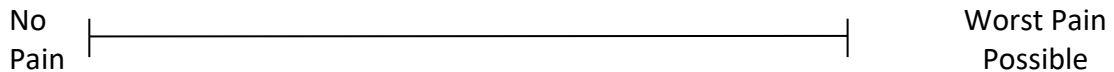
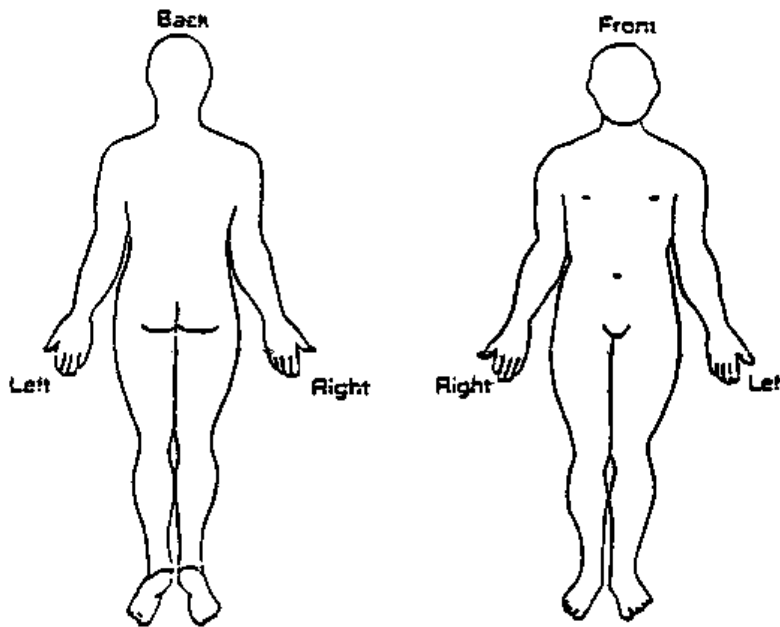
Draw the location of your pain on body outlines and mark how bad it is on pain line at bottom of page.

Indicate location and the type of pain using the following chart:

1 – Ache	2 – Burning	3 – Numbness
4 – Pins and Needles	5 – Stabbing	6 – Other



Please make a slash through this line as to the level of your pain



Please make a slash through this line as to the level of your pain

Patient's Signature	Date:
---------------------	-------