Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385, 860-572-7711, www.fwcct.com

Empowering LIFE

Date_____ Insurance_____

Patients First Name: _____ MI____ Last Name_____
Address: _____
City: _____ State_____ Zip_____
SS# _____ Gender_____ Age_____ Nickname_____
DOB ____/____/_____

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax_____
E-mail:_____
Spouse/Parent Name: _____ Marital Status: _____

Emergency Contact Information
Name_____
Phone_____ Relationship_____

Amount of physical activity performed at work_____
_____

Amount of physical activity a day_____

Reason for seeing the doctor_____

What are your goals for this visit? _____
_____

List Current Medications/Supplements/Treatment Protocols_____
_____
_____
_____

How did you hear about us? _____

How has this condition effected your LIFE? _____

Who can we thank for your referral? _____

How can we help Empower your LIFE?_____

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Social & Family History

Live with: ☐ Family ☐ Spouse ☐ Significant Other ☐ Friend ☐ Alone

Children: ☐ Yes ☐ No Ages: _____

Smoking History: ☐ Currently ☐ In the Past Years_____ Amount_____

Alcohol: ☐Yes ☐ No Amount_____ Substance Abuse: ☐ Yes ☐ No Type: _____

Education Level: ☐ Grade School ☐ High School ☐ College

Medical History

Yes	No	Do you have?	Yes	No	Do you have?
☐	☐	Allergies to any medications	☐	☐	Cardiac Pacemaker
☐	☐	History of cancer or a tumor	☐	☐	Any other heart problem
☐	☐	History of radiation	☐	☐	History of blood clots/phlebitis
☐	☐	History of chemotherapy	☐	☐	History of any blood disorder
☐	☐	History of surgery	☐	☐	History of ulcers
☐	☐	Previous hospitalizations	☐	☐	History of intestinal hemorrhage
☐	☐	Diabetes	☐	☐	History of depression
☐	☐	Thyroid disease/problems	☐	☐	History of anxiety disorder
☐	☐	Recent unexplained weight change	☐	☐	History of suicide thought/ attempts
☐	☐	Collagen vascular disease/problems	☐	☐	Kidney disease/problems
☐	☐	Lyme disease	☐	☐	Liver disease/problems
☐	☐	HIV or AIDS	☐	☐	Prostate disease/problems (men)
☐	☐	Hepatitis B	☐	☐	Ovarian/Uterine disease problems(w)
☐	☐	Arthritis	☐	☐	Dizziness or Vertigo
☐	☐	Glaucoma	☐	☐	History of TIA
☐	☐	Asthma	☐	☐	History of Stroke
☐	☐	Emphysema	☐	☐	Loss of consciousness (black out/faint)
☐	☐	Shortness of breath	☐	☐	History of seizures
☐	☐	Chronic cough	☐	☐	Multiple sclerosis
☐	☐	History of tuberculosis	☐	☐	Migraine headache
☐	☐	Angina/chest pain/Irregular heart beat	☐	☐	Chronic headache
☐	☐	Leg pain with walking	☐	☐	Blurred/double vision
☐	☐	Heart murmur	☐	☐	Other neurological problems
☐	☐	History of rheumatic fever	☐	☐	Drug dependency
☐	☐	History of heart attack	☐	☐	Alcohol addiction
☐	☐	Congestive heart failure	☐	☐	Metal fragments in body
☐	☐	High Blood Pressure	☐	☐	**Are you Currently Pregnant?**

Medication History

Yes	No	Are you Taking Medication	Yes	No	Are You Taking Medication
☐	☐	For diabetes	☐	☐	To help you sleep
☐	☐	For a heart problem	☐	☐	To calm your nerves
☐	☐	For high blood pressure	☐	☐	For depression
☐	☐	To reduce body fluids	☐	☐	For pain
☐	☐	To thin the blood	☐	☐	For muscle spasm
☐	☐	For asthma	☐	☐	For bladder control
☐	☐	For bronchitis	☐	☐	Steroids
☐	☐	For another lung problem	☐	☐	Birth Control Pills
☐	☐	For stomach or bowel problems	☐	☐	Chemotherapy
☐	☐	For glaucoma	☐	☐	Other medication not listed

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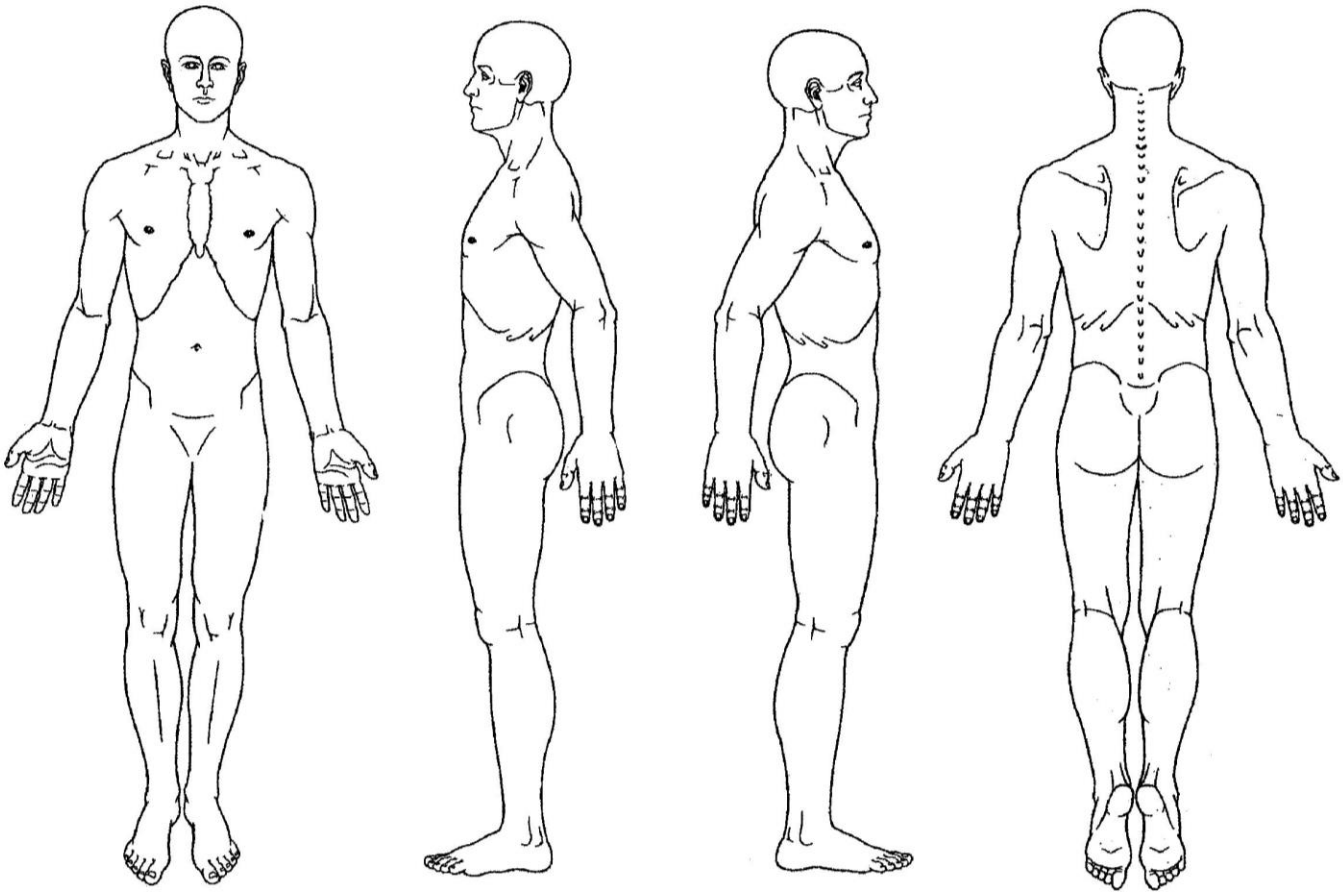
PAIN DRAWING

Name_____ Date_____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^	=======	OOOOOOOO	. . . . .	/////////	XXXX
^^^	=======	OOOOOOO	. . . . .	///////	XXX



No Pain ——————————— Worst Possible Pain

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

_____

Patient Signature

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PAIN QUESTIONNAIRE

When did your pain begin? _____
Please describe how it began: _____
Is your pain related to an injury? ☐ Yes ☐ No
Since your pain began, is it: ☐ Better ☐ Worse ☐ About the Same
Have you resumed your normal activities of daily living? ☐ Yes ☐ No
Are you disable from your usual employment? ☐ Yes ☐ No ☐ Type of Work_____
If so, what is the date you were last able to work? _____
What medications are you currently taking for your pain? _____

Where is your pain?

☐ Head	☐ Forearm Rt/Lt/Both	☐ Low Back Rt/Lt/Both	☐ Groin Rt/Lt/Both
☐ Neck Rt /Lt/ Both	☐ Hand Rt/Lt/Both	☐ Buttocks Rt/Lt/ Both	☐ Knee Rt/Lt/Both
☐ Shoulder Rt/Lt/Both	☐ Upper Back Rt/Lt/Both	☐ Hips Rt/Lt/Both	☐ Calf Rt/Lt/Both
☐ Upper Arm R/Lt/Both	☐ Chest Rt/Lt/Both	☐ Leg Rt/Lt/Both	☐ Foot Rt/Lt/Both

Describe your pain?

☐ Sharp_____	☐ Stabbing_____	☐ Dull_____	☐ Achy_____
☐ Shooting_____	☐ Throbbing _____	☐ Burning_____	☐ Cramping_____
☐ Numbness_____	☐ Tingling_____	☐ Pressure-like_____	☐ Other_____

How often do you experience the pain?
☐ Constant (100%-75%) ☐ Frequent (75%-50%) ☐ Intermittent (50%-25%) ☐ Occasional (25%-1%)

What aggravates your pain?

☐ Sitting Down	☐ Sitting for long period	☐ Standing	☐ Standing for long periods	☐ Deep Breathing
☐ Walking	☐ Walking for long periods	☐ Lying Down	☐ Flexing Forward	☐ Sleeping
☐ Lifting	☐ Coughing	☐ Sneezing	☐ Straining	
☐ Specific Movement(s) _____			☐ Other_____	

What relieves your pain?
☐ Sitting Down ☐Standing ☐ Walking ☐ Lying Down ☐ Massage ☐ Therapy ☐ Rest ☐ Moist Heat/Hot Shower
☐ Exercise ☐ Sleeping ☐ Ice ☐ Stretching ☐ Medications_____

PREVIOUS TREATMENT

What type of treatment have you received so far?
☐ Physical Therapy_____
☐ Chiropractic_____
☐ Acupuncture_____
☐ Epidural Steroid Injections _____
☐ Trigger Point Injections or Nerve Blocks _____
☐ Surgery_____
☐ Massage_____

DIAGNOSTIC TESTING

What diagnostic tests have you have completed so far and when?

☐ MRI Cervical Spine_____	☐ MRI Lumbar Spine_____	☐ MRI other _____
☐ X-Rays _____	☐ EMG/NCV_____	☐ Other tests_____

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The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices (the "Notice") is available for your review. This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of Your Health Information:** We may use the information we develop and collect for treatment by our practice or disclose the information to others to who we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcription service, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. **Other Uses and Disclosures:** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights**: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:

a. You may request restrictions on certain uses and disclosures of your information
b. You may request that you receive your information from us in a certain way
c. You may inspect and copy your medical records
d. You may request an amendment to any record you believe is inaccurate
e. You may request an accounting of disclosures made of your records

4. **Changes to the Notice:** We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.

5. **Complaints:** You may file a complaint to our Privacy Official Dr. Kendra Becker or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

Policy has been made available for me for review.

Signature:_____ Soc. Sec. # _____-____-_____

Name:_____ **Date:** _____