WOODHAVEN
HEALTH

NEW PATIENT PAPERWORK

GENERAL INFORMATION

NAME: _____ AGE: _____ SEX: Male / Female
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
CELL PHONE: _____ BIRTHDATE: _____
EMAIL ADDRESS: _____
REFERRED BY: _____

Please Select Payment Option: ○ Keep Card on File ○ At Time of Service

INSURANCE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and I am ultimately responsible for any unpaid balances.

Patient Signature: _____ Date: _____
Insurance Company: _____ Phone: _____
ID/Subscriber #:_____ Group #: _____

CONSENT FOR CARE

I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: _____ Date: _____

HIPAA NOTICE

I acknowledge the following:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): _____

Patient Signature: _____ Date: _____

Woodhaven Health PC
600 Blair Park Rd. Ste 260
Williston, VT 05495
Phone: (802) 857-5099
Fax: (802) 857-5179
contact@woodhavenhealth.com

WHAT BRINGS YOU IN TODAY?

Location of pain/symptoms: _____
What would you rate your pain at it's worst (1-10, ten being the worse pain possible): _____
Please describe the pain: _____
Any numbness or tingling: Yes / No Where: _____
Any radiating or shooting pain/symptoms: Yes / No Where: _____
When did this begin: _____
How did this happen: _____
Is this related to auto accident or work injury: Yes / No Which one: Auto / Work
What makes your pain/symptoms worse: _____
What help or relieves you pain/symptoms: _____
Is there a time of the day that your pain/symptoms are better or worse: _____
Have you experienced these pain/symptoms before: Yes / No When: _____
Who have you seen for this: _____
What did they do: _____
How did you respond: _____

LIFESTYLE

Do you exercise? Yes / No How often and what activities: _____
Do you smoke? Yes / No How much per day: _____
Do you drink alcohol? Yes / No How much per week: _____
Do you drink caffeine? Yes / No How much per day: _____
How many cups of water do you drink per day: _____
List any vitamins and supplements: _____
List any medications: _____

HEALTH CONDITIONS

Cervical (Neck) Region:

- Neck Pain
- Headaches/Migraines
- Seizures/Epilepsy
- Pain in shoulders/arms/hands
- Dizziness
- TMJ pain/clicking
- Weakness in grip
- Numb/tingling in arms/hands

Thoracic (upper and middle back) Region:

- Upper back pain
- Middle back pain
- Pain in ribs/chest
- Pain on deep breathing

Lumbar (low back) or Pelvis (hips) Region:

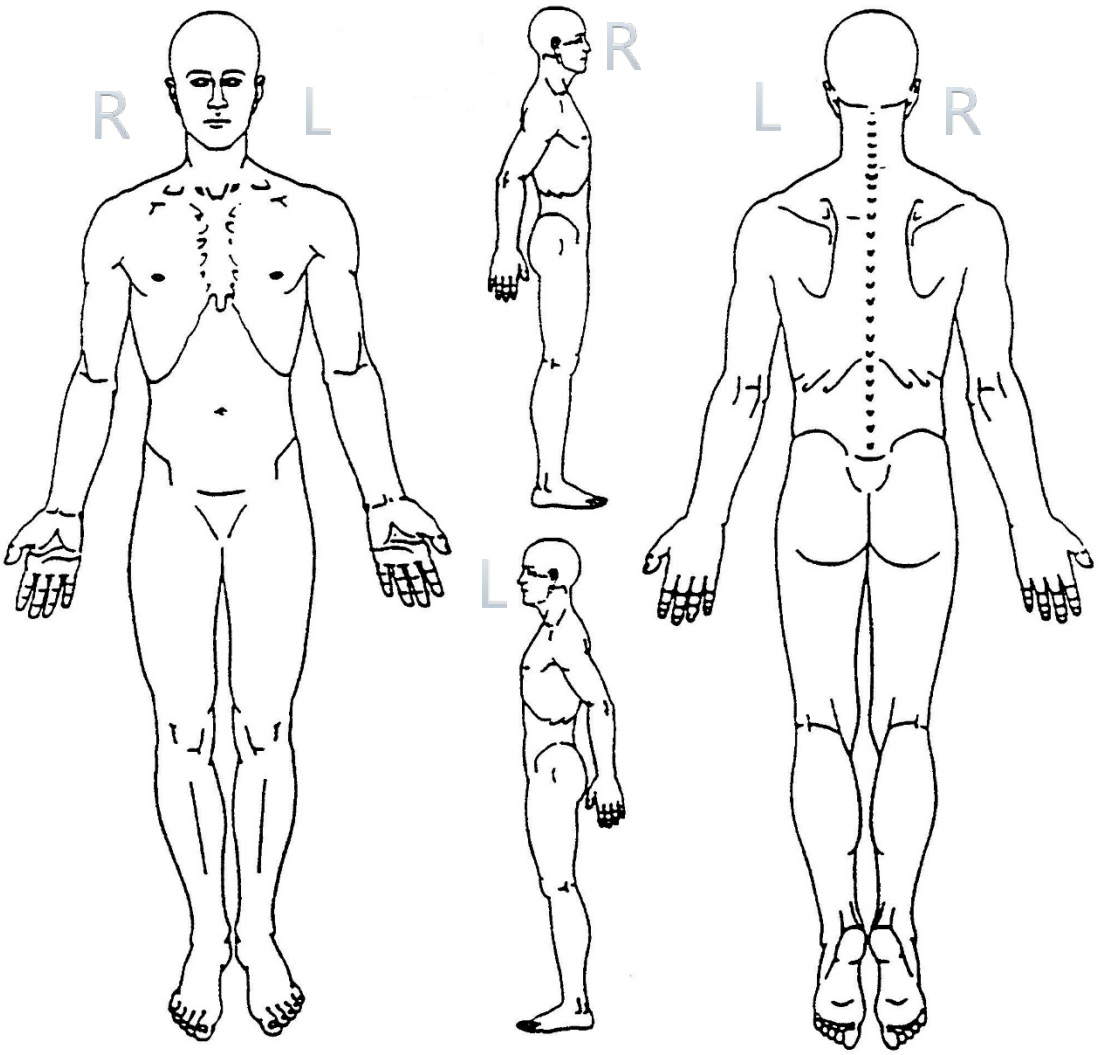
- Low back pain
- Pain in hips/legs/feet
- Weak in legs/feet
- Numb/tingling in legs/feet

List any allergies: _____
_____
List all surgeries with date: _____
_____
List any other health condition not mentioned: _____
_____

PAIN DIAGRAM

Use the symbols below to show the area, upon the body outline, in which you are experiencing pain.

Ache – A Burn – B Numbness – N Pins & Needles – P Stabbing – S Other – O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale that indicates how much pain you are experiencing ***at this time.***

No Pain 0 ——————————————————————————— **10 Worst Pain**