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: ☐Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.					
Last Name					
First Name	Middle Initial				
Address					
City		State		Zip	
Primary Phone ( )		Mobile Phone ( )			
Email:					
Date of Birth: / /	Age	Sex: ☐ Male ☐Female ☐Other			
Marital Status: (Check One) ☐ Single ☐ Married ☐ Other					
Emergency Contact:		Phone: ( )			
Primary Care Provider:		Phone: ( )			
Primary Care Provider Address:					
☐ Please do not share the results of this visit with this provider					
Race: Please Check One					
☐ White	☐ Black/African American	☐ American Indian/Alaskan Native		☐ Asian	
☐ Native Hawaiian/other Pacific Island		☐ Other	☐ Choose not to Specify		
Ethnicity: Please Check One					
☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Choose not to Specify			
Preferred Language: Please Check One					
☐ English	☐ Spanish	☐ Chinese	☐ French	☐ Tagalog	☐ American Sign Language
☐ Other				☐ Choose not to Specify	

Are you the patient, or are you completing this for the patient?
☐ I am the patient. ☐ I am completing this for the patient. Is the patient a minor? ☐ Yes ☐ No
If you are completing this form for the patient, please enter your name:

Employment Status: Please Check One					
☐ Employed Full Time	☐ Employed Part-time		☐ FT Student	☐ PT Student	
☐ Retired	☐ Self-Employed		☐ 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? ☐ Yes ☐ 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:
☐ Physician Referral (Please indicate Name)
☐ Personal Referral (Please indicate Name)
☐Phone Book ☐ Internet Search ☐ Other (Please Specify)

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

<u>Payment Verification</u>: 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

<u>General Verification</u>: 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 ☐	
1.	2.
3.	4.
5.	6.
7.	8.
Please list any ALLERGIES you have to medications. If NO known allergies, check here ☐	
1.	2.
3.	4.
Do you use tobacco of any type? ☐ Yes ☐ No ☐ Former Tobacco User ☐ Never Used Tobacco	
If Yes, how often do you use tobacco? ☐ Current every day user ☐ 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"?	

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Do you presently have a diagnosis of Hypertension?	☐ Yes ☐ No
Do you presently have a diagnosis of Diabetes? ☐	☐ Yes ☐ No
If "Yes" to Diabetes, what kind?	☐ Type I ☐ Type II
If "Yes" to Diabetes, do you know your A1C level?	☐ Yes ☐ No ☐ 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? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Prior Interventions: What have you done to relieve the symptoms? Please Check all that apply

☐ Prescription Medicine	☐ Acupuncture	☐ Over the Counter Medication	☐ Ice
☐ Homeopathic Remedies	☐ Chiropractic	☐ Physical Therapy	☐ Heat
☐ Massage	☐ Other		

Please Continue on the Reverse

New Patient Information	Date:
Patient Name:	

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident or Injury:

Have you reported this accident to:

☐ Auto Insurance ☐ Employer ☐ Workers' Comp. ☐ Other ☐ 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
☐	No Issues	☐	No Issues	☐	No Issues	☐	No Issues
☐	Osteoporosis	☐	High Blood Pressure	☐	Thyroid Issues	☐	Asthma
☐	Arthritis	☐	Low Blood Pressure	☐	Immune Disorders	☐	Apnea
☐	Scoliosis	☐	High Cholesterol	☐	Hypoglycemia	☐	Emphysema
☐	Neck Pain	☐	Poor Circulation	☐	Frequent Infection	☐	Hay Fever
☐	Back Problems	☐	Angina	☐	Swollen Glands	☐	Shortness of Breath
☐	Hip Disorders	☐	Excessive Bruising	☐	Low Energy	☐	Pneumonia
☐	Knee Injuries	☐	Other	☐	Other	☐	Other
☐	Elbow/Wrist Pain						
☐	TMJ Issues		**Digestive**		**Genitourinary**		**Integumentary**
☐	Foot/ankle Pain	☐	No Issues	☐	No Issues	☐	No Issues
☐	Poor Posture	☐	Anorexia/Bulimia	☐	Kidney Stones	☐	Skin Cancer
☐	Shoulder Problems	☐	Ulcer	☐	Infertility	☐	Psoriasis
☐	Other	☐	Food sensitivities	☐	Bedwetting	☐	Eczema
	Neurological	☐	Heartburn	☐	Prostate Issues	☐	Acne
☐	No Issues	☐	Constipation	☐	Erectile Dysfunction	☐	Swollen Glands
☐	Anxiety	☐	Diarrhea	☐	PMS Symptoms	☐	Rash
☐	Depression	☐	Other	☐	Other	☐	Other
☐	Headache		**Sensory**		**Constitutional**		
☐	Dizziness	☐	No Issues	☐	No Issues		
☐	Pins and Needles	☐	Blurred Vision	☐	Fainting		
☐	Numbness	☐	Ringing in Ears	☐	Low Libido		
☐	Other	☐	Hearing Loss	☐	Poor Appetite		
		☐	Loss of Smell	☐	Fatigue		
		☐	Loss of taste	☐	Erectile Dysfunction		
		☐	Chronic Ear Infection	☐	Weakness		
		☐	Other	☐	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:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 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:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 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? ☐ Yes ☐ No	

Please rate your eating habits where 0 means your eating habits are UNHEALTHY and 10 means your eating habits are HEALTHY:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What are your typical eating habits:

☐ Skip Breakfast	☐ 2 Meals per Day	☐ 3 Meals per Day	☐ 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?

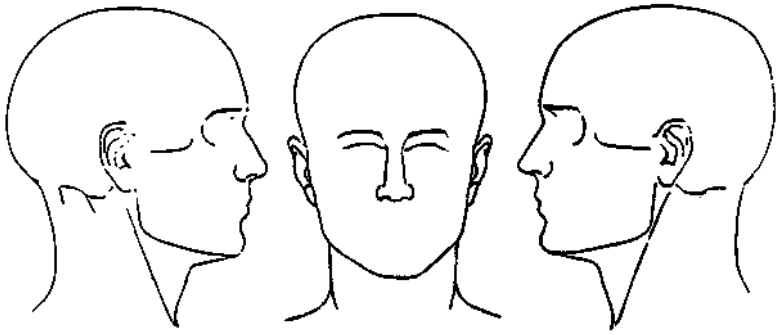
Patient Signature:

Pain Diagram

Patient's Name: _____

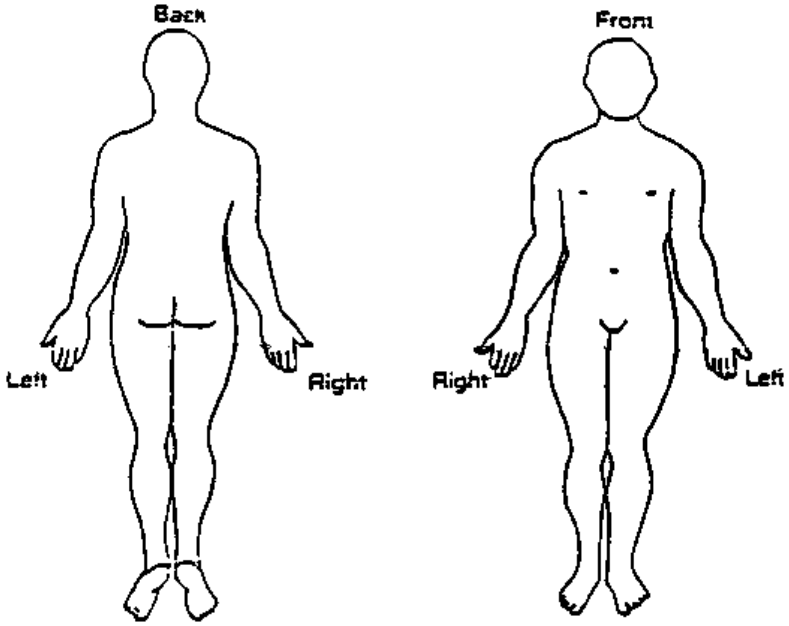
Draw the location of your pain on body outlines and mark how bad it is on pain line at bottom of page.
Indicate location and the type of pain using the following chart:

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



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

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



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

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

Patient's Signature	Date: