

Center for TEAM Healthcare
NEW PATIENT QUESTIONNAIRE

Name: _____

Date: _____

Referred by: _____

Birthdate: _____

HISTORY OF PRESENT INJURY

Date problem began: _____ Work Related Auto Accident Other

Describe your symptoms and how they began: _____

Have you consulted with any other physicians for your present condition? Yes No

If yes, please list names of physicians consulted: _____

How many hours a day do you experience pain? _____

How many days per week do you experience pain? _____

Have you had these problems before? Yes No If yes, please explain below:

PAST MEDICAL HISTORY

Please check any medical condition you have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Stress/Depression | <input type="checkbox"/> Previous Head Trauma |
| <input type="checkbox"/> Previous Fracture/Dislocated Bones (list by date): _____ | | |
| <input type="checkbox"/> Other: _____ | | |

List any surgical procedures you have undergone in the past (list by date): _____

Indicate if you have undergone any of the following studies and the results as you understand them:

	When	Where	Results
<input type="checkbox"/> Plain X-rays	_____	_____	_____
<input type="checkbox"/> CT Scan	_____	_____	_____
<input type="checkbox"/> MRI	_____	_____	_____

CURRENT MEDICATIONS and/or SUPPLEMENTS or VITAMINS

Please list any medications you are currently taking and what they are for:

- _____

ALLERGIES and SENSITIVITIES

Please list reactions you may have or have had in the past to any medications:

Medication	Reaction
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	_____

Notice of Privacy for: Patient's Protected Health Information "HIPPA"

Center for TEAM HealthCare abides by the terms described in this policy. This paper describes how health care information about you may be used and disclosed and how you can get access to this information. Take a moment to read this notice.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-in logs may be disclosed to verify office visits.

Any other uses of disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr Donald Cofer and can be reached at: 435.649.1542 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received the reviewed this notice with full understanding.

Name of Patient (print)

Signature of Patient/Legal Representative

Date