APPOINTMENT CHECKLIST :

- If you have any recent x-ray's and/or MRI's (within the last 6 months), please bring them with you to the consultation.

- Expect to be in the office for up to 2 hours.

- Make sure you have your Photo ID and insurance card(s) with you upon arrival to the office.

- Please have your paperwork filled out prior to arriving for your consultation.

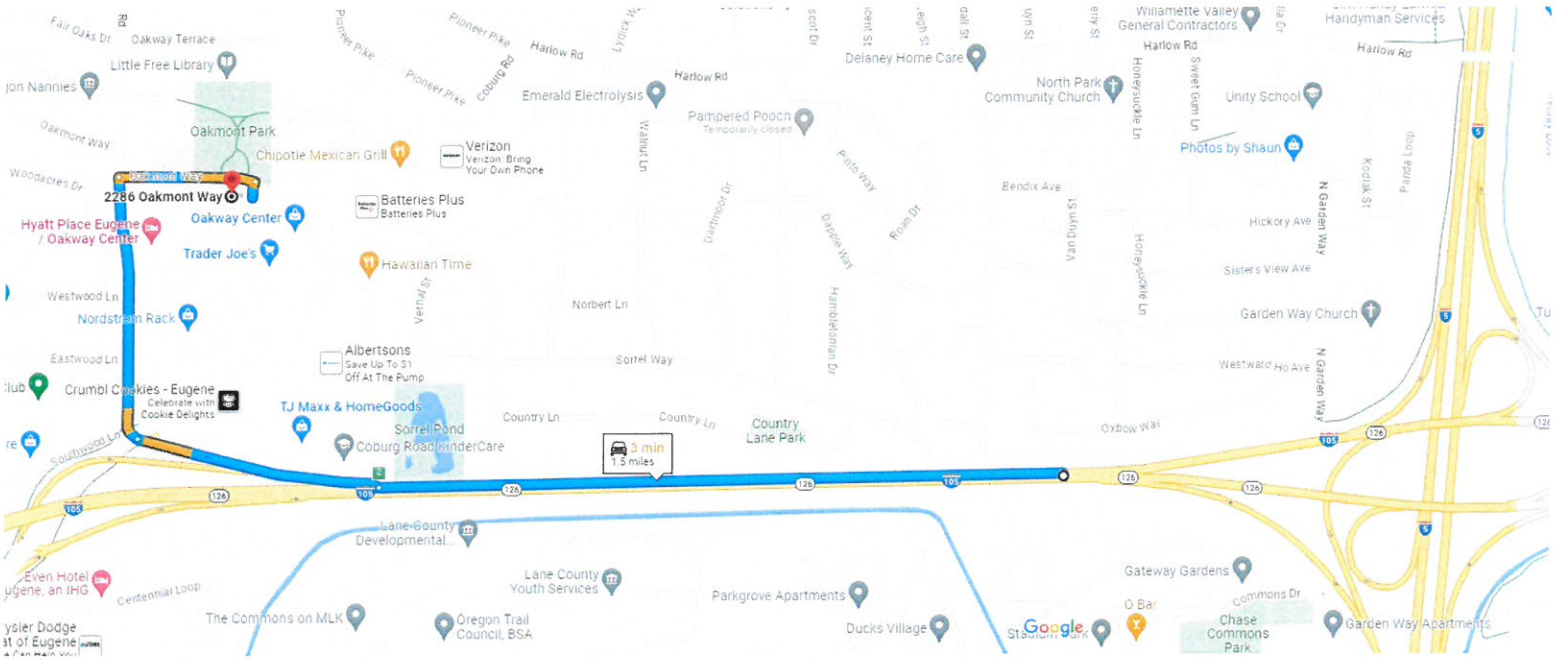
- Please understand we have set this time out for you with our Medical Provider and Case Manager, and we ask that you arrive on time for your appointment.

- Please make sure you write down and bring any questions with you to the consultation!

Thank you!

Absolute
Wellness Center

2286 Oakmont Way, Eugene OR 97401
Phone: 541-484-5777 Fax: 541-284-2704



Directions from I-5 North:

- Head South on I-5 and take exit 194B to merge onto I-105 W
- Take exit 2 for Coburg Road
- Continue slight right onto Oakway Road
- Turn right onto Oakmont Way
- Take the second right into the parking lot
- Our office will be on the left-hand side immediately in the parking lot

Directions from I-5 South:

- Head North on I-5 and take exit 194B to merge onto I-105 W
- Take exit 2 for Coburg Road
- Continue slight right onto Oakway Road
- Turn right onto Oakmont Way
- Take the second right into the parking lot
- Our office will be on the left-hand side immediately in the parking lot

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PATIENT INFORMATION

Patient Name_____ Today's Date_____ Email_____

DOB_____ SSN/SIN_____ Home Phone_____Cell_____

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Seperated ☐Male ☐Female

Patient's Address_____ City_____ State_____ Zip_____

Employer Name_____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Alternate Contact Information Authorization

Absolute Wellness Center has my authorization to:

Y **N** Leave medical information on my home/cell answering machine.

Y **N** Text my cell phone reminders for my appointments.

Emergency Contact Information

I authorize Absolute Wellness Center to contact the below-mentioned person only in the case of an emergency. Below listed mentioned person (unless listed under Family/Friends Release of Information may not receive additional information regarding my care:

Emergency Contact: Name_____ Relation_____ Phone_____

Family/Friends Release of Information Authorization

I authorize Absolute Wellness Center to discuss **ANY** information regarding my care with the below-mentioned persons:

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Patient Name_____ DOB_____

FINANCIAL

Responsible Party

Person responsible for the account is the same as the patient ☐ Yes *(skip portion below)* ☐ No

Name of the person responsible for this account _____ Relation to patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver's License Number/State_____ Date of Birth_____

Is this person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical Insurance? ☐ **Yes** ☐ **No** **If yes, complete the following:**

Primary Insurance

Insurance Company_____ ID #_____ Group #_____

Name of the Policy Holder_____ Relationship to patient_____

Insurance Company Phone Number _____

Secondary Insurance

Insurance Company_____ ID #_____ Group #_____

Name of the Policy Holder_____ Relationship to patient_____

Insurance Company Phone Number _____

Patient Name_____ DOB_____

HEALTH HISTORY

Chief Complaint_____

History of Present Illness

Location:_____
(Where is the pain/problem?)

Quality:_____
(Example: Sharp, dull, achy, tight, numb, etc.)

Severity:_____
(How severe is the pain/problem on a scale of 1-10 with being the most severe?)

Duration:_____
(How long have you had this pain/problem? When did it start?)

Timing:_____
(Does the pain/problem occur at a specific time?)

Context:_____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms:_____
_____
(What other associated problems have you been having?)

Modifying Factors:_____
_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Are you currently pregnant or lactating? ☐ Yes ☐ No

Indicate which of the following you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**		**General**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Fatigue	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Malaise	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Sore Throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Irritability	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5	Constipation	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	Diarrhea	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Feeling foggy	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Earache/Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5		
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5		
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5		
Shortness of Breath	1 2 3 4 5	Upper Back Pain	1 2 3 4 5		

Patient Name_____ DOB_____

Indicate which of the following you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Numbness	1 2 3 4 5
Dizziness	1 2 3 4 5
Tingling in Hands/Feet	1 2 3 4 5

Past Medical History

Have you ever had the following: *(Circle "yes" or "no"/leave blank if you are uncertain)*

Diabetes I or II	YES | NO	Stroke	YES | NO	Whooping Cough	YES | NO	Blood/Plasma Transfusion	YES | NO
Cancer	YES | NO	Anemia	YES | NO	Bladder Infection	YES | NO	Organ Transplant	YES | NO
Chicken Pox	YES | NO	Back Trouble	YES | NO	High Blood Pressure	YES | NO	Mitral Valve Prolapse	YES | NO
Ulcer	YES | NO	Epilepsy	YES | NO	Low Blood Pressure	YES | NO	Kidney Disease	YES | NO
Scarlet Fever	YES | NO	Hepatitis	YES | NO	Hemorrhoids	YES | NO	Thyroid Disease	YES | NO
Diphtheria	YES | NO	Tuberculosis	YES | NO	Hives or Eczema	YES | NO	Infections	YES | NO
Arthritis	YES | NO	Hernia	YES | NO	Bronchitis	YES | NO	DVT/Blood Clot	YES | NO
Venereal Disease	YES | NO	Glaucoma	YES | NO	Migraine Headaches	YES | NO	Date of last chest X-Ray	_____
Smallpox	YES | NO	Measles	YES | NO	AIDS/HIV	YES | NO	If current infection, please list:	
Mumps	YES | NO	Asthma	YES | NO	Mononucleosis	YES | NO	_____	
Pneumonia	YES | NO	Polio	YES | NO	Rheumatic Fever	YES | NO	_____	

Any other diseases:

Patient Name_____ DOB_____

Past Medical History, continued

Have you ever had a spinal fusion?	When?	Hospital, City, State

Other Hospitalizations/Surgeries/Serious Illnesses:	When?	Hospital, City, State

Please list any implanted medical devices below (ie: pacemaker, insulin pump, spinal stimulator, etc):

_____

_____

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs:: ☐ Never ☐ Yes; Type/Frequency_____

Excessive Exposure

At home or at work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Patient Name_____ DOB_____

Family Medical History

	Age	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Grandparents			
Children			

Patient Name_____ DOB_____

MEDICATIONS

Please include prescription and non prescription medications

Medication Name	Dosage	Frequency

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Are you currently taking any medications for acid indigestion (prescription or over the counter)?

☐ Yes ☐ No If yes, what type? _____

You may encounter the following items at our clinic; do you have an allergy to any of the following?

Adhesives, Latex, Lidocaine, ChloraPrep: ☐ Yes ☐ No

If yes, which one? _____

Medication Allergies: _____

_____

Patient Name_____ DOB_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform necessary services I may need.

_____ _____

Signature of the patient, parent, or guardian Date

Medical Provider's Review

_____ _____

Signature of Medical Provider Date Reviewed