Mind Body Spirit Care

www.mindbodyspiritcare.com

Patient Intake Registration & Questionnaire

Please print clear and legibly. Dr. Shemesh requests that you fill out all pages completely.

First Name________________________ Last Name _________________________________Middle Initial____________

Address_____________________________________Hm#_______________Cell#_____________Wk#_______________

E-mail_______________________________________DOB________________SS#_______________________________

Male______ Female______ Single____ Married____ Divorced_____ Separated_____ Widowed_____

Race: Caucasian___ Black___ Hispanic___ Asian____ Etniticity: Latino / Hispanic____ Other_____

Referred By ____

Spouse's Name____

Emergency Contact Name _____________________________Ph#___________________Relationship_______________

Primary Insurance__________________________________

Policy Holder's Name ____Relationship to Policy Holder_________________

Policy#________________________ Grp#______________ Policy Holder's SS#___________________& DOB__________

Secondary Insurance________________________________

Policy Holder's Name ____Relationship to Policy Holder_________________

Policy#________________________ Grp#______________ Policy Holder's SS#___________________& DOB__________

Employer Name___________________________Address_____________________________________Ph#___________

REASON FOR TODAY'S VISIT: ____

SOCIAL HISTORY

Please select the option that best describes you in each category. In some areas you may only need to select one option whereas in other areas, selecting more than one may be more appropriate. Feel free to add any extra comments you may feel are important. The more we know up front, the better we can understand what's going on with your overall health.

Do you drink alcohol [ ] Yes [ ] No

Social drinker [ ] Yes [ ] No

Never drank [ ] Yes [ ] No

Recovering alcoholic [ ] Yes [ ] No

Stopped drinking on this date_______________

Smoker [ ] Yes [ ] No

Never smoked [ ] Yes

Chewing tobacco [ ] Yes

Wishing to stop [ ] Yes

Unsuccessful at stopping [ ] Yes

Previous history of smoking [ ] Yes

Quit smoking on this date__________________ ☺

Occupation ___________________________

Change in Job___________________________

Physical or Emotional abuse by a family member? [ ] Yes [ ] No

Do you exercise on a regular basis? [ ] Yes [ ] No

Anything else that you feel may be important?

____

____

____

____

____

PLEASE LIST ALL ALLERGIES (medication and non-medication)

1. ____________________ **4.** ____________________ **Latex Allergy?**
2. ____________________ **5.**____________________ [ ] Yes [ ] No
3. ____________________ **6.**____________________

Primary Care Providers Name and Phone Number ____

Preferred Pharmacy Name and Phone Number ____

MEDICATIONS & SUPPLEMENTS

Name	Dosage	Name	Dosage
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

Date of last menstrual period______________________ Cycles are Regular _________ Irregular________

First Menstrual period was at age?__________ Bleeding last for ________Days

Any problems or issues with menses?
____

Date of last pap smear____________________________ Results were Normal _______Abnormal________
Date of last mammogram__________________________ Results were Normal _______Abnormal________
Date of last bone density__________________________ Results were Normal _______Abnormal________
Date of last colonoscopy __________________________ Results were Normal _______Abnormal________
MEN ONLY:
Date of last prostate exam? _______________________ Results were Normal_______ Abnormal________

History of Menopause? [ ] Yes [ ] No Symptoms started at age:________________
Comments: ____
Using Contraceptive? [ ] Yes [ ] No Method of Birth Control:____
Comments:____

Number of pregnancies__________ Names/Ages of Children
Live births/living children_________
Miscarriages/Aborts_______

Name	Year Born

Are you or could you be PREGNANT?________________________

REVIEW OF SYSTEMS - Please circle all that apply.

Generalized pain
Feeling tired or poorly
Feeling better since last visit
Fever
Chills
Night sweats
Recent weight gain _______lbs.
Recent weight loss _______ lbs.
Headaches
Facial pain
Sinus pain

Vision problems
Sensitivity to light
Pain in or around the eyes
Swelling around eyes
Red eyes
Eye irritation
Growth on eye(s)
Neck pain
Neck Stiffness
Lump/Swelling in the neck

Earache
Loss of hearing
Ringing in the ears
Nosebleeds
Nasal discharge
Mouth sores
Bleeding gums
Hoarseness
Sore throat
Itching skin
Skin lesions
Rashes
Nails break easily

Pain with urination
Delays in starting
Feelings of urgency
Blood in the urine
Incomplete emptying of the bladder
Temporary loss of control
Loss of urine w sudden movement (cough,sneeze)
Genital lesion(s)
Swelling in the groin
Urinary freq. more than 2X per night
Inadequacy of penile erection
Sexual interest has decreased

Excessive sweating
Excessive thirst
Libido has changed (sex drive)
Temperature intolerance
Hot Flashes
Swollen glands in the neck

Joint Pain
Joint Stiffness
Joint Swelling

Muscle aches
Soft tissue swelling
Muscle Weakness
Legs feel Restless
Muscle spasms
Muscle cramps

Change in Appetite
Difficulty in Swallowing
Heartburn
Nausea
Vomiting
Abdominal Pain

Diarrhea
Black or Tarry Stools
Constipation
Bloating
Gas (flatus)
Change in stool Color
Change in stool Characteristics

Stool Consistency has changed
Bowel Movements per day________
Bowel Movements per week_______

Allergic Reaction from:
Seasonal __________________
from Contact______________
Ingested Food_______________
from Inhalation______________

Chest Pain
Fast heart rate
Heart palpitations
Cold hands or feet

Dizziness
Spinning dizziness (vertigo)
Fainting

Shortness of Breath
Cough
Wheezing
Coughing up blood

Sleep disturbances
Anxiety
Depression
Excessive Crying
Emotional lability (mood swings)
Highly irritable
Cravings for _____________?

REVIEW OF SYSTEMS (continued)

FEMALES ONLY:

Breast Pain
Nipple discharge
Breast lump
Breast swelling
Vulva (outside of the vagina) itching or burning
Vulva lump or mass

Pelvic pain
Pelvic pressure

Pain during intercourse
Feeling of something bulging from vagina
Bleeding between periods
Severe pain with period (dysmenorrhea)
Excessive bleeding during period (menorrhagia)

Vaginal dryness
Vaginal discharge color_____________
Vaginal itching or burning
Vaginal odor

Typical interval for the amount of time between periods is _______ days.

Has the time between periods increased (less freq bleeding)? [ ] Yes [ ] No

OR

Has the time between periods decreased (more freq bleeding)? [ ] Yes [ ] No

If yes to either increased or decreased: Preceding interval was _______ days

PAST MEDICAL/SURGICAL HISTORY

Please list ALL Surgeries/Hospitalizations and dates associated

Appendectomy date:____________

Back Surgery date:____________

Breast Surgery (type___________) date:____________

Coronary Artery Heart Bypass date:____________

Hernia date:____________

Hysterectomy/ovaries removed Y or N date:____________

Knee / Hip (circle) Surgery date:____________

Tonsillectomy date:____________

Vasectomy date:____________

Other: _________________________ date:____________

Do you bruise easily?
[ ] Yes [ ] No

Do you bleed easily?
[ ] Yes [ ] No

Have you ever had a reaction to anesthesia?
[ ] Yes [ ] No

MOTHER: Living [ ] Yes [ ] No Health Status: Good Fair Poor

Deceased at what age?___________ Cause?____

FATHER: Living [ ] Yes [ ] No Health Status: Good Fair Poor

Deceased at what age?___________ Cause?____

PERSONAL & FAMILY HISTORY Please place an X in the corresponding boxes.

	MYSELF	MOTHER	FATHER	OTHER Family Member (Sibling, Aunt/Uncle, Cousin, Grandmother/ Grandfather) please specify mother or fathers side.	Notes:
Adverse reaction to anesthesia					
Alcoholism					
Allergies					
Alzheimer's					
Anxiety					
Arthritis					
Asthma					
Bleeding problems					
Breast Cancer					
Cancer					
Colon Cancer					
Depression					
Diabetes					
Glaucoma					
Heart Disease					
Heart Attack					
HIV Infection					
Hypoglycemia					
Hypertension					
Kidney Disease					
Liver Disease					
Lung Disease					
Psychiatric Disorders					
Migraine headaches					
Ovarian Cancer					
Seizure Disorder					
Sickle Cell Anemia					
Sickle Cell Trait					
Stroke Syndrome					
Thyroid Disorder					
Uterine Cancer					
Other:					

Please tell us a little about each of the items below IF they are currently happening in your life NOW. Sometimes we don't realize how much we are dealing with on a daily basis and how it could play a role in our well being. Providing this information is optional. However, by doing so you are giving Dr. Shemesh the best insight in order for him to give you the best treatment options available for your situation.

Relationship changes____

Family disruption____

Interpersonal problems____

Family problems____

Work related events____

Financial status change____

Legal problems____

Current diet____

Illegal Drug use____

Caffeine use____

Life event____

Under stress____

Other____
____
____

Thank you for taking the time to fill out and provide this valuable information regarding your mind, body and spirit (overall health). We want you to know that we look forward to working with you on your journey to optimal health!

Signature______________________________Date__________________

No-Show Policy

Mind Body Spirit Care has implemented a “No Show / Cancellation Policy”

medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. We therefore request that patients who are unable to keep their scheduled appointments notify us at least 24 hours in advance, so the time might be made available to someone else.

Please be aware that you will be charged a $50.00 no-show fee if you are not able to keep an appointment with any practitioners at Mind Body Spirit Care and fail to cancel 24 hours prior to your appointment time. The purpose of this fee is to decrease the rate of “no show” appointments, which adversely affects the ability of other patients being able to schedule an appointment in a timely manner.

A missed appointment, or "no-show," occurs when a patient fails to give a 24 HOUR notice that the appointment cannot be kept.

By signing below, I am aware that Mind Body Spirit Care will charge me a $50.00 no show fee if I am unable to keep an appointment with Dr. Shemesh or any practitioner of Mind Body Spirit Care and do not cancel the appointment with a 24 Hour Notice that the appointment cannot be kept.

________________________________ ___________________________________

Printed Name Date

____

Signature