BAIN COMPLETE WELLNESS®

Patient _____ DOB _____/_____/_____

TELL US ABOUT YOU (please print)

First _____ MI _____ Last _____
Address 1 _____
Address 2 _____ CITY _____ ST _____ ZIP _____ COUNTRY _____
E-mail _____ ☐ Opt out of providing E-mail Address
Language Preference _____ SSN _____ - _____ - _____ DOB _____/_____/_____
Driver's License # _____ ST _____
Phone 1 _____ CELL HOME BUSINESS
Phone 2 _____ CELL HOME BUSINESS
Appointment Reminder Preferred Contact Method PHONE TEXT EMAIL

Gender	Race	Status
M F	☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ DECLINE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ HISPANIC	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

Employment ☐ EMPLOYED ☐ DISABLED ☐ RETIRED ☐ PART-TIME Employer _____

Student Status ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT School _____

Emergency Contact Name _____
Relationship _____ Phone _____
Primary Care Physician _____ Phone _____
Did a Physician Refer you to us? YES NO Physician Name _____

How did you hear about us? _____

HEALTH INSURANCE (enter N/A if not applicable)

Insurance Company Name _____
Policy Type _____ Member Number _____
Group Number _____ Group Name _____
Effective from Date _____/_____/_____ Effective To Date _____/_____/_____

Secondary Insurance if applicable

Insurance Company Name _____
Policy Type _____ Member Number _____
Group Number _____ Group Name _____
Effective from Date _____/_____/_____ Effective To Date _____/_____/_____

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Information required by law. Complete only if the Primary Policy holder is NOT the patient.

Relationship to Primary Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ MOTHER ☐ FATHER ☐ OTHER _____

Primary Insured Name _____

Address 1 _____

Address 2 _____ CITY _____ ST _____ ZIP _____

Phone 1 _____ CELL HOME BUSINESS DOB _____/_____/_____ Gender M F

Current Bain Complete Wellness Patient? YES NO

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Services? YES NO If YES, Name of Agency? _____

If YES, what type of Home Health Services are you receiving? _____ Last Date of Service _____

Are you currently a patient at a Skilled Nursing Facility? YES NO If YES, Name of facility? _____

If Medicare, have you received PT, OT, or Speech services since the first of the year? YES NO

- If YES, do you know if you have exceeded your Medicare Therapy Cap amount? YES NO
- Are you aware of any partial amount used since the first of the year? $ _____.
- If YES, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

TELL US WHY YOU ARE HERE (please print)

What is the primary reason for your visit? _____

Where is the pain located? _____

Does the pain go anywhere from there? _____

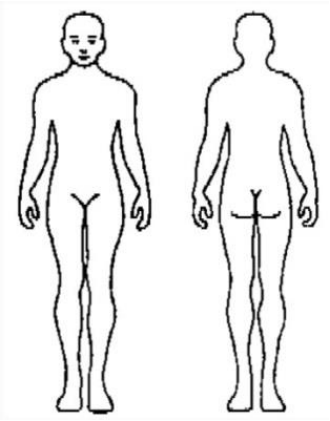
Did the pain start suddenly or gradually and get worse? _____

Does anything make the pain better? (e.g., ice, heat, medications, rest, etc.) _____

Does anything make the pain worse? (e.g., moving, standing, sitting, etc.) _____

What does the pain feel like? (e.g., sharp, numb, tingly, achy, etc.) _____

How long have you had the pain? _____



Is your pain? ☐ OCCASIONAL ☐ INTERMITTENT ☐ FREQUENT ☐ CONSTANT

On a scale of 0-10, please rate your pain/symptom today?

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst Possible

Mark an X on the picture where you have pain.

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PAST MEDICAL HISTORY (please circle all that apply)

DIAGNOSES

Denial of any significant medical history	Hematologic disorder	Anemia	Coronary artery disease (heart attack)	STD
Headache	Abdominal pain	Anxiety	Cancer	Chest pain
Cataract	Glaucoma	Hearing loss	Edema	Heart disease
Congestive heart failure	Hypertension	DVT of lower extremity	Emphysema	Esophageal reflux
Pneumonia	Asthma	Chronic obstructive pulmonary disease	Diverticulitis of colon	Irritable bowel syndrome
Gastric ulcer	Colitis	Polyps of colon	Hepatitis	Chronic liver disease
Hemorrhoids	Cholelithiasis (gallstones)	Cholecystitis (gall bladder disorder)	Hyperlipidemia	Obesity
Chronic kidney disease	Nephrolithiasis	Urinary tract infection	Polycystic ovarian syndrome	Psoriasis
Thyroid disorder	Osteoporosis	Diabetes mellitus	Migraine	TIA
Arthritis	Gout	SLE	Sleep apnea	Tuberculosis
CVA	Dementia	Depression	Colon cancer	Breast cancer

Other _____

SURGICAL

Please notate the year of the surgery next to the type.

Tonsillectomy	Heart surgery	Varicose vein ligation	Mastectomy	Splenectomy
Appendectomy	Hemorrhoidectomy	Cholecystectomy	Hernia repair	Vasectomy
Hysterectomy	Cesarean section	Prostatectomy	Back surgery	Hip surgery
Knee surgery	Fusions	Laminectomy	Hernia	

Other _____

RECENT EVENTS

Recent staphylococcal infection	Recent streptococcal infection	Recent upper respiratory infection	Recurrent urinary tract infections

Other _____

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REPORTED MEDICAL HISTORY

Recent hospitalizations? Please list _____

_____

Recent emergency room visits? _____

Recent psychiatric treatment? _____

SLEEP HISTORY

How many hours of sleep do you get on an average night? _____

What time do you go to sleep? _____ What time do you wake up? _____

Do you have difficulty falling asleep? YES NO Do you snore? YES NO

How do you sleep? ☐ BACK ☐ FRONT ☐ SIDE

PSYCHOLOGY HISTORY

Have you ever had psychiatric or psychological counseling? YES NO

Do you currently have emotional or psychological problems that concern you? YES NO

SOCIAL HISTORY (please circle all that apply)

BEHAVIORAL HISTORY

CAFFEINE USAGE YES NO If YES, how much per day? _____

TOBACCO USAGE

Current every day smoker | Current some day smoker | Packs per day?_____ | Previous history of smoking | Never smoked

ALCOHOL USAGE YES NO If YES, drinks per week? _____

Beer consumption	Wine consumption	Drinking in moderation -2 drinks/day or less
Recent increases in alcohol consumption	Recent decrease in alcohol consumption	Stopped drinking alcohol
Previous attempts to decrease alcohol consumption		Recovering alcoholic

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SOCIAL HISTORY continued (please circle all that apply)

DRUG USAGE YES NO If YES, Please circle all that apply.

Barbiturates	Marijuana	Heroin
Amphetamines	Cocaine	

EXERCISE YES NO If YES, how often per week? _____ How long per work out? _____

SEXUALLY ACTIVE YES NO

Other _____

FAMILY HISTORY

Please check all items that apply to your family members.

FAMILY MEMBER	Not in Good Health	Deceased	Diabetes mellitus	Cancer*	Chronic kidney disease	Heart disease	Systemic HTN	Obesity	Hyperlipidemia	Osteoporosis
FATHER										
MOTHER										
BROTHER(S)										
SISTER(S)										
DAUGHTER(S)										
SON(S)										

Type of Cancer * _____

Other _____

_____

_____

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MEDICATIONS/SUPPLEMENTS CURRENTLY ON OR HAVE PREVIOUSLY USED

If you have a current list of medications, please allow the front desk staff to make a copy rather than fill out the list below.

Date Started	Medication Supplement Name	Dose Given	Frequency of Use (e.g., 2x per day)	Time (AM or PM)

Do you use any Medical Equipment (e.g., cane, brace, wheelchair, etc.) _____

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ALLERGIES			
FOOD	**ENVIRONMENTAL (e.g., pollen, dust)**	**MEDICINE**	**OTHER**

_____ **Date** _____/_____/_____

Patient Signature

Intake Completed By _____ **Date** _____/_____/_____

Implementation Date:	**Revision Date:**