HEALTH 1ST
Wellness & Physical Medicine

HEALTH 1ST WELLNESS & PHYSICAL MEDICINE
804 HIGDON FERRY ROAD, HOT SPRINGS, AR 71913
(501) 881-4407

Patient Name____ Date: ______________________ Email: ____________________________

SS #/SIN:_________________________ DOB:______________________________ ☐ Male ☐ Female

Home phone:_____________________ Cell Phone _________________________

Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address: ____City: _______________ State: ______ Zip: ____________

Employer Name: ____

Spouse or Patient's Guardian name: _____________________________ Spouse's Employer: ____________________________________

Whom may we thank for referring you? ____

Person to contact in case of an emergency: ____ Phone: ______________________________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ______________________________________
Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account ______________________________Relationship to Patient ____________________

Address ____Home Phone _____________________________

E-Mail ____Cell Phone ______________________________

Driver's License # _________________________________ Date of Birth: ____

Is the person currently a patient at our office? □ Yes □ No

Do you have any medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured____ Relationship to patient__________________________

Birthdate___________________ SS#/SIN_________________________ Name of Employer_________________ Work Phone __________

Address of Employer____ State ____________ Zip_______________________________

Insurance Company______________________________ Group #_________________ ID # _____________________________________

Ins. Co. Address _____________________________________ City _________________ State _________ Zip________________________

Health History

Health Concerns/Symptoms

Chief Complaint: ____
Describe your main concerns (symptoms, onset, diagnoses, duration, etc.)

When did your chief problem or illness begin? ____

What are your goals for today's visit and for your long-term health?

____

Past Medical History

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

Condition			Condition			Condition		
ADD/ADHD	**Yes**	**No**	Diabetes	**Yes**	**No**	Mental Disorder	**Yes**	**No**
AIDS/HIV	**Yes**	**No**	Diverticulitis	**Yes**	**No**	Mental Illness	**Yes**	**No**
Alcohol Overuse/Alcohol Abuse	**Yes**	**No**	Ear or Hearing Problems	**Yes**	**No**	Muscle, Joint, or Bone Problems	**Yes**	**No**
Allergies/Hayfever	**Yes**	**No**	Eating Disorder	**Yes**	**No**	Neck Pain	**Yes**	**No**
Anemia	**Yes**	**No**	Eczema	**Yes**	**No**	Neuropathy	**Yes**	**No**
Anesthesia Complications	**Yes**	**No**	Emphysema	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Aneurysm	**Yes**	**No**	Endometriosis	**Yes**	**No**	Osteopenia	**Yes**	**No**
Ankylosing Spondylitis	**Yes**	**No**	Falls	**Yes**	**No**	Ostomy	**Yes**	**No**
Anxiety Disorder	**Yes**	**No**	Fibromyalgia	**Yes**	**No**	Ovarian Cancer	**Yes**	**No**
Arrhythmia	**Yes**	**No**	GI Problems	**Yes**	**No**	Pacemaker	**Yes**	**No**
Arthritis	**Yes**	**No**	Gout	**Yes**	**No**	Peripheral Vascular Disease	**Yes**	**No**
Asthma	**Yes**	**No**	Head Trauma/Injury	**Yes**	**No**	Polyps	**Yes**	**No**
Autism Spectrum Disorder (ASD)	**Yes**	**No**	Headaches	**Yes**	**No**	Prostate Problems	**Yes**	**No**
Autoimmune disease	**Yes**	**No**	Heart Attack (MI)	**Yes**	**No**	Pulmonary Embolism	**Yes**	**No**
Back Pain	**Yes**	**No**	Heart Disease	**Yes**	**No**	Reflux/GERD	**Yes**	**No**
Birth Defects or Inherited Disease	**Yes**	**No**	Heart Problems	**Yes**	**No**	Rheumatoid Arthritis	**Yes**	**No**
Bladder or Kidney Problems	**Yes**	**No**	Hepatitis	**Yes**	**No**	Seizures/Epilepsy	**Yes**	**No**
Bleeding Disorder	**Yes**	**No**	High Cholesterol	**Yes**	**No**	Serious Illness or Injuries	**Yes**	**No**
Blood Clot	**Yes**	**No**	Hospitalizations	**Yes**	**No**	Skin Problems	**Yes**	**No**
Blood Diseases	**Yes**	**No**	Hypertension	**Yes**	**No**	Sleep Apnea	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Hyperthyroidism	**Yes**	**No**	Sleep Disorder	**Yes**	**No**
Brain Injury	**Yes**	**No**	Hypothyroidism	**Yes**	**No**	Stroke	**Yes**	**No**
Breast Cancer	**Yes**	**No**	Joint Pain	**Yes**	**No**	Thrombophilias	**Yes**	**No**
Cancer	**Yes**	**No**	Kidney Disease	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Congestive Heart Failure (CHF)	**Yes**	**No**	Kidney Stones	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Constipation	**Yes**	**No**	Leg or Foot Ulcers	**Yes**	**No**	Urinary Problems	**Yes**	**No**
COPD	**Yes**	**No**	Liver Disease	**Yes**	**No**	Varicosities	**Yes**	**No**
Crohn's Disease	**Yes**	**No**	Lung Disease	**Yes**	**No**	Vascular Disease	**Yes**	**No**
Depression	**Yes**	**No**	Meniere's disease	**Yes**	**No**	Vision or Eye Problems	**Yes**	**No**

Past Surgical History

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

Surgery			Surgery			Surgery		
Adenoid Surg.	**Yes**	**No**	Gastrostomy Tube	**Yes**	**No**	Rhinoplasty	**Yes**	**No**
Amputation	**Yes**	**No**	General Surg.	**Yes**	**No**	Septoplasty	**Yes**	**No**
Angioplasty	**Yes**	**No**	Gyn Surg.	**Yes**	**No**	Shoulder Surg.	**Yes**	**No**
Ankle/Foot Surg.	**Yes**	**No**	HEENT Surg.	**Yes**	**No**	Spine Surg.	**Yes**	**No**
Appendectomy	**Yes**	**No**	Hemorrhoidectomy	**Yes**	**No**	Splenectomy	**Yes**	**No**
Arthroscopic Surg.	**Yes**	**No**	Hernia Repair	**Yes**	**No**	Stent	**Yes**	**No**
Back Surg.	**Yes**	**No**	Hip Replacement	**Yes**	**No**	Strabismus Surg.	**Yes**	**No**
Bariatric Surg.	**Yes**	**No**	Hip Surg.	**Yes**	**No**	Thyroid Surg.	**Yes**	**No**
Bilateral Mastectomy	**Yes**	**No**	Hydrocele Repair	**Yes**	**No**	Thyroidectomy	**Yes**	**No**
Breast Biopsy	**Yes**	**No**	Hypospadias Repair	**Yes**	**No**	Tonsillectomy	**Yes**	**No**
Breast Surg.	**Yes**	**No**	Hysterectomy	**Yes**	**No**	Total Colectomy	**Yes**	**No**
Bronchoscopy	**Yes**	**No**	Hysteroscopy	**Yes**	**No**	Total Hysterectomy	**Yes**	**No**
Bypass	**Yes**	**No**	Joint Replacement	**Yes**	**No**	Tubal Ligation	**Yes**	**No**

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CABG	**Yes**	**No**	Knee Replacement	**Yes**	**No**	Vasectomy	**Yes**	**No**
Caesarean Section	**Yes**	**No**	Knee Surg.	**Yes**	**No**	VP Shunt Placement	**Yes**	**No**
Cancer Surg.	**Yes**	**No**	Laparoscopy	**Yes**	**No**	Other: ___________________________		
Cardiac Surg.	**Yes**	**No**	Laparotomy	**Yes**	**No**	Other: ___________________________		
Cardiovascular Surg.	**Yes**	**No**	LASIK	**Yes**	**No**	Other: ___________________________		
Carotid Endarterectomy	**Yes**	**No**	LEEP	**Yes**	**No**			
Carpal Tunnel Surg.	**Yes**	**No**	Liver Biopsy	**Yes**	**No**			
Cataract Surg.	**Yes**	**No**	Lumbar Spine Surg.	**Yes**	**No**			
Cholecystectomy	**Yes**	**No**	Mastectomy	**Yes**	**No**			
Colon Surg.	**Yes**	**No**	Myomectomy	**Yes**	**No**			
Colonoscopy	**Yes**	**No**	NeuroSurg.	**Yes**	**No**			
Colposcopy	**Yes**	**No**	Nissen Fundoplication	**Yes**	**No**			
Dilation and Curettage	**Yes**	**No**	Oophorectomy	**Yes**	**No**			
Dilation and Evacuation	**Yes**	**No**	Orthopedic Surg.	**Yes**	**No**			
Ear Tube	**Yes**	**No**	Other	**Yes**	**No**			
ENT Surg.	**Yes**	**No**	Ovarian Cystectomy	**Yes**	**No**			
Eye Surg.	**Yes**	**No**	Pacemaker	**Yes**	**No**			
Flexible Sigmoidoscopy	**Yes**	**No**	Partial Hysterectomy	**Yes**	**No**			
Fracture Surg.	**Yes**	**No**	Plastic Surg.	**Yes**	**No**			
Frenulectomy	**Yes**	**No**	Prostate Surg.	**Yes**	**No**			
Gallbladder Surg.	**Yes**	**No**	Prostatectomy	**Yes**	**No**			
Gastric Bypass	**Yes**	**No**	Pyloric Stenosis Repair	**Yes**	**No**			
Gastrointestinal Surg.	**Yes**	**No**	Reconstructive Surg.	**Yes**	**No**			

Medication: (include over-the-counter)

____
____
____

Patient Social History:

Use of Alcohol Never: ______ Rarely: _______ Moderate: _______ Daily: _________
Use of Tobacco Never: ______ Rarely: _______ Moderate: _______ Daily: _________
Use of Drugs Never: ______ Type/Frequency: ____
Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: _______ Noise: _______

Family Medical History

(Do any of the following family members have a history of the following? Place an "X" in the box below)

	Heart Disease	**Cancer**	**Hypertension**	**Diabetes**
Father				
Mother				
Sibling				
Grandparent				

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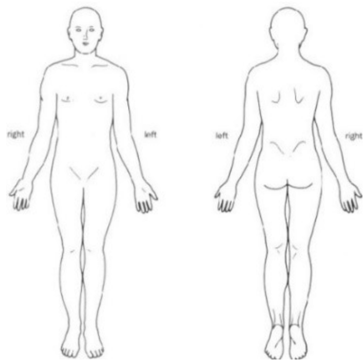
Current Medical History

Indicate which of the below 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**		**Neurological**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Sore Throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Tingling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5	Pins/needles in hands/feet	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	**General**	
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Fatigue	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Malaise	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5	Weakness, Tiredness	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Irritability	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t Shoulder Blades	1 2 3 4 5	Constipation	1 2 3 4 5
Wheezing	1 2 3 4 5			Diarrhea	1 2 3 4 5
				Feeling Foggy	1 2 3 4 5
				Forgetfulness	1 2 3 4 5



On the diagram to the left, mark the areas of your symptoms. Use the following symbols to indicate the characteristics of the symptoms:
Sharp Pain=X, Ache=0, Numbness=N,
Tingling=T, Burning=B, Weakness=W

In order of importance, list the health problems you are most interested in getting corrected:

1. ____
2. ____
3. ____

CURRENT PAIN LEVELS

How would you rate your pain the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect 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 healthcare staff to perform the necessary services I may need.

____ ____________________

Signature of the Patient, Parent or Guardian Date