

SPRINGFIELD OFFICE:

1 Hayden Bridge Way, Springfield, OR 97477

FLORENCE OFFICE:

340 9th Street, Florence, OR 97439



Patient Registration

PATIENT INFORMATION

Name: _____

Preferred Nickname: _____

Date of Birth: _____ Sex: []M []F

Social Security #: _____

Address: _____

City, State: _____

Phone: _____ [X]Home []Work []Other

Phone: _____ []Home [X]Work []Other

Phone: _____ Cell

Doctor: _____

Referring Physician: _____

Primary Physician: _____

Employment Status: []Employed []Retired []Unemployed

Employer: _____

Work Phone: _____

Email: _____

Marital Status: []Married []Single []Divorced

SPOUSE OR PARENT INFO

Spouse or Parent: _____

Social Security #: _____

Address: _____

Employer: _____

Work Phone: _____

If applicable, check which applies: Work Injury (see below) Auto Injury (Date: _____) Accident (Date: _____)

INSURANCE INFORMATION

If you would like us to bill your insurance, please bring a copy of your insurance card with you to your appointment.

Primary Insurance Company: _____

Policy/Group Number: _____

Subscriber ID: _____

Name of Subscriber: _____

Date of Birth: _____

Secondary Insurance Company: _____

Policy/Group Number: _____

Subscriber ID: _____

Name of Subscriber: _____

Date of Birth: _____

WORK INJURY

Date of Injury: _____

Claim Number: _____

Employer at date of injury: _____

On-the-job Insurance Company: _____

PATIENT DOB: _____ / _____ / _____
MONTH DAY YEAR

PATIENT NAME: _____
LAST FIRST MI

Patient Medical History: Please mark all that apply

<input type="checkbox"/> Abnormal Heartbeat	<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stomach Cancer
<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety/Panic Attacks	<input type="checkbox"/> Dementia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pancreatic Cancer	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> IBS	<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> TIA
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes, Childhood	<input type="checkbox"/> Kidney Cancer	<input type="checkbox"/> Passing Out/Fainting	<input type="checkbox"/> Tremor
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Diabetes, Adult Onset	<input type="checkbox"/> Liver Cancer	<input type="checkbox"/> Peptic Ulcer Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> B12 Deficiency	<input type="checkbox"/> Esophageal Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pituitary Tumor	<input type="checkbox"/> Uterine Cancer
<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Rectal Cancer	<input type="checkbox"/> None
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Head/Neck Cancer	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Skin Cancer	
<input type="checkbox"/> Brain Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Seizures/Epilepsy	
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Severe Anesthesia Complications	
<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sexually Transmitted Diseases	
<input type="checkbox"/> Chronic Back/Neck Pain	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Neurological Disease	<input type="checkbox"/> Shingles	
<input type="checkbox"/> Other:				

Patient Surgical History: Please mark all that apply

<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Orthopedic (Bone)
<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Heart Stent	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Brain Aneurysm	<input type="checkbox"/> Cataract Removal
<input type="checkbox"/> Carotid Artery	<input type="checkbox"/> Weight Loss Surgery
<input type="checkbox"/> Leg Artery	<input type="checkbox"/> Carpal Tunnel Release
<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Transplant	<input type="checkbox"/> None
<input type="checkbox"/> Other:	

Prior Neurodiagnostic Testing: Please mark all that apply

MRI

Date(s):

Testing Facility:

- Head
- Neck
- Lumbar
- Other:

- Oregon Imaging Center
- Willamette Valley Imaging
- Other:

CT

Date(s):

Testing Facility:

- Head
- Neck
- Lumbar
- Other:

- Sacred Heart Hospital
- McKenzie-Willamette Hospital
- Other:

NCV/EMG

Date(s):

Testing Facility:

EEG

Date(s):

Testing Facility:

- Sacred Heart Hospital
- McKenzie-Willamette Hospital
- Other:

Family History

- Family History is unknown (if yes, skip to **Social History**)
- Family History is unremarkable

Coronary Heart Disease (CHD): please check all that apply

- No Family History of CHD

Yes, Family History of CHD in:

- Father, younger than 55
- Brother, younger than 55
- Son, younger than 55
- Mother, younger than 65
- Sister, younger than 65
- Daughter, younger than 65

Family History

Please mark all that apply:

	Father	Mother	Sibling	Grandparent
Abnormal Heartbeat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Atrial Fibrillation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B12 Deficiency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dementia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lymphoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Melanoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neuropathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parkinson Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Passing Out/Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pituitary Tumor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prostate Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures/Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tremor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Social History

Women Only:

Do you use birth control? (circle one) YES NO

Are you pregnant? (circle one) YES NO

Are you considering becoming pregnant? (circle one) YES NO

Social History

Do you have children? (circle one) YES NO

Status of Mother: (circle one) ALIVE DECEASED UNKNOWN

If deceased, died of: _____ Age at death: _____

Status of Father: (circle one) ALIVE DECEASED UNKNOWN

If deceased, died of: _____ Age at death: _____

Tobacco Use:

(circle one) Never Former Current

If current or former tobacco user: (circle one) Cigarettes Smokeless Tobacco

Year Started: _____ Current Packs/Day: _____ Year Quit: _____ Previous Packs/Day: _____

Alcohol Use:

How often have you had a drink containing alcohol in the past year? (select one)

- Never Monthly or Less 2-4 times a month 2 or 3 times a week +4 times a week

How many drinks do you have on a typical day when you were drinking in the past year? (select one)

- 1 or 2 3 or 4 5 or 6 7 to 9 + 10

How often did you have 6 or more drinks on one occasion during the past year? (select one)

- Never Less than monthly Monthly Weekly Daily Almost Daily

Drug Use:

(circle one) Never Previous Current

If current or previous, which ones? (mark all that apply)

- Heroin Methamphetamine Cocaine
 Marijuana Illicit Prescriptions Other: _____

Caffeine Use, daily: (select one) 0-1 cups 2-3 cups 4-5 cups + 6 cups

Marital Status: (select one) Married Widowed
 Single Domestic Partner
 Divorced

Employment Status: (select one) Part-Time Unemployed
 Full-Time Disabled
 Homemaker Retired

Social History

Education Level: (select one)

- 8th grade or less
- High School
- Some college
- Two year degree
- Four year degree
- Graduate School

Patient's Dominant Hand: (select one)

- Left
- Right

Medications

Please list all prescription and over-the-counter medications you are taking at this time

Name of Medication	Dosage/Strength	# Per Day

Allergies

Please list all allergies (including environmental, medication, and food)

Demographic Information:

Preferred Language English Spanish Other:

Ethnicity Hispanic or Latino NOT Hispanic or Latino Declined Other:

Race American Indian Asian Black or African American Other:
 Native Hawaiian White Declined