INSIGHT WELLNESS CENTER

NEW PATIENT QUESTIONAIRE

We ask that you fill this form out and return it 1 week prior to your visit otherwise your appointment may need to be rescheduled.
This questionnaire is confidential and will be kept as part of your medical record.
Returning patients need only to fill out changed or updated information.

~ Please print clearly ~

☐ INSURANCE CLAIM ☐ WORKER'S COMP ☐ AUTO CLAIM

RETURNING PATIENTS NEED ONLY TO FILL OUT CHANGED OR UPDATED INFORMATION

PATIENT INFORMATION (Please Print) DATE:

PATIENT'S NAME FIRST MIDDLE LAST	SEX ☐ M ☐ F	DATE OF BIRTH	SOCIAL SECURITY NO.

Dear Patient: You will be asked questions regarding race and ethnicity during the registration process. We do not ask these questions to limit or deny you services. We ask these questions to give you better care. By gathering this data, we can better prevent, test for, and treat the diseases or health conditions that may affect you. You may refuse to provide us with this information. You will only be asked these questions once.

RACE ❑Asian ❑Black, African or African American ❑American Indian or Alaskan Native ❑White ❑Native Hawaiian or other Pacific Islander ❑Other Races ❑Two or more races ❑Unknown

ETHNICITY ❑ Hispanic or Latino ❑ Neither

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO. ( )

E-MAIL	CELL PHONE NO. ( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	WORK PHONE NO. (INCLUDE EXT.) ( )

OCCUPATION (DESCRIBE YOUR JOB DUTIES)	ACTIVE RETIRED DISABLED DATE

ARE YOU ON DISABILITY? ☐YES ☐NO	ARE YOU IN THE PROCESS OF OBTAINING DISABILITY? ☐YES ☐NO

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	PHONE NO. ( )

REFERRING DOCTOR (NAME AND PHONE NUMBER)	FAMILY DOCTOR (NAME AND PHONE NUMBER)

HOW DID YOU HEAR ABOUT US?	PHARMACY NAME	PHONE NO. ( )	FAX NO. ( )

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

SECONDARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

I AUTHORIZE INSIGHT TO RELEASE ANY OF MY MEDICAL RECORDS FROM ANY HOSPITAL OR OTHER FACILITY I HAVE BEEN TREATED AT AND TO RELEASE ANY OF MY MEDICAL RECORDS TO THE FOLLOWING PEOPLE (Physicians, Lawyers, etc.) AND TO BE SPOKEN TO IN REGARDS TO MY MEDICAL CARE:

NAME	PHONE	FAX
NAME	PHONE	FAX

Patient's or authorized person's signature: I, the undersigned, authorize payment of medical benefits to the doctor for services rendered to me by the physician. I understand I am financially responsible for all co-pays, deductibles, or services not covered or considered not medically necessary. I authorize release of information concerning health care, advice, treatment, or supplies provided to me, to my insurance carrier. The information will be used only for the purpose of evaluation and administering claims for benefits.

SIGNATURE DATE

Medicare patients: Medicare lifetime signature on file: I request that payment of authorized Medicare benefits be made on my behalf to the physician for any services rendered to me by the physician. I authorize any holder of medical information about me to be released to health care financing administration and its agents. I also authorize any information needed to determine these benefits payable for related services released to the health care financing administration or its agents.

SIGNATURE DATE

Name: _____ DOB: _____

I am interested in Buprenorphine because I am addicted to: Heroin Opioids: specify

Drug use	Never	Use Now (How often)	Quit (Date last used)	Route of administration
Amphetamines	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Marijuana	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Cocaine	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Benzodiazepine	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Heroin	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Opioids	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
Others: specify	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐
	☐	☐	☐	Orally ☐ Nasally ☐ Smoking ☐ Injection ☐

Date of first substance use: _____	**Under what circumstances?** ❑experimental use ❑after hanging with drug users ❑follow a trauma or stress, specify:_____ ❑other, specify: _____

List Previous and Current Treatments for Substance use

Rate how much help in terms of improvement in daily, social and occupational activities

Name and dose of Medication	Good help	Some help	No help	Side Effects: Specify		Interventions	Good help	Some help	No help
1. Metadone	❑	❑	❑			Counseling	❑	❑	❑
2. Buprenorphine	❑	❑	❑			Support Group	❑	❑	❑
3.	❑	❑	❑			Rehabilitation	❑	❑	❑
4.	❑	❑	❑			Other:	❑	❑	❑
5.	❑	❑	❑				❑	❑	❑

Unsuccessful efforts to quit substance use?	☐ Yes	☐ No
Substance use continues despite harmful consequences?	☐ Yes	☐ No
Increasingly neglect social and occupational activities in favor of substance use?	☐ Yes	☐ No
Experience "withdrawal" after going without substance?	☐ Yes	☐ No
Require larger amounts of substance to achieve the same effects “tolerance”?	☐ Yes	☐ No
What ‘triggers’ make substance use worse?	Social stressors	Others-specify:

Medical History: Check ALL conditions that apply to you ❑ NONE

High Blood Pressure
- ☐ Essential Primary Hypertension (I10)

Blood Clots/Embolism
- ☐ Personal History of other venous thrombosis and embolism (Z86.718)

Diabetes
- ☐ Type 2 diabetes with diabetic neuropathy (E11.40)
- ☐ Type 2 diabetes with unspecified complications (E11.8)
- ☐ Type 2 diabetes unspecified (E11.9)

COPD
- ☐ Chronic obstructive pulmonary disease (J44.9)

High Cholesterol
- ☐ Pure Hypercholesterolemia, Unspecified (e78.00)

Chronic Bronchitis
- ☐ Simple chronic bronchitis (J41.0)

Asthma
- ☐ Unspecified asthma (J45.909)

Arthritis
- ☐ Unsepcified Osteoarthritis (M19.90)

Osteoporosis
- ☐ Age-related osteoporosis without current pathological fracture (M81.0)

Pacemaker
- ☐ Presence of cardiac pacemaker (Z95.0)

Heart Attack
- ☐ Old Myocardial Infarction (I25.2)

TIA (Mini Stroke)
- ☐ Transient Cerebral Ischemic Attack, Unspecified

Ulcers
- ☐ Personal History of Diseases of the skin and subcutaneous tissue (Z87.2)

Emphysema
- ☐ Other emphysema (J43.8)

Rheumatoid Arthritis
- ☐ Rheumatoid arthritis with rheumatoid factor (M05.9)
- ☐ Rheumatoid myopathy with rheumatoid arthritis of unspecified site (M05.40)

Hepatitis C
- ☐ Chronic viral hepatitis C (B18.2)

Cirrhosis of the liver
- ☐ Alcoholic cirrhosis of liver without ascites(K70.30)
- ☐ with ascites (K70.31)
- ☐ Other chirrhosis of liver (K74.89)

Renal/Kidney disease
- ☐ End stage renal disease (N18.6)
- ☐ Chronic kidney disease stage 1 (N18.1)
- ☐ Chronic kidney disease stage 2 (N18.2)
- ☐ Chronic kidney disease stage 3 (N18.3)
- ☐ Chronic kidney disease stage 4 (N18.4)
- ☐ Chronic kidney disease stage 5 (N18.5)

Alzheimers/Dementia
- ☐ Alzheimer's disease with early onset (G30.0)
- ☐ Alzheimer's disease with late onset (G30.1)
- ☐ Alzheimer's unspecified (G30.9)
- ☐ Unspecified dementia without behavioral disturbance (F03.90)
- ☐ Unspecified dementia with behavior disturbance (F03.91)

Depression/Bipolar Disorder
- ☐ Major depressive disorder, recurrent, moderate (F33.1)
- ☐ Bipolar II disorder (F31.81)
- ☐ Other bipolar disorder (F31.89)

Schizophrenia
- ☐ Paranoid schizophrenia unspecified (F20.0)
- ☐ Unspecified schizophrenia (F20.3)

Multiple Sclerosis
- ☐ Multiple sclerosis (G35)

Epilepsy/Seizures
- ☐ Other epilepsy not intractable (G40.802)
- ☐ Seizures (G40.89)

Heart Failure/Atrial Fibrillation/Unstable Angina
- ☐ Heart failure unspecified (I50.9)
- ☐ Unspecified atrial fibrillation and atrial flutter (I48.9)
- ☐ Unstable angina (I20.0)

Stroke
- ☐ Other cerebral infarction (I63.8)
- ☐ Cerebral infarction unspecified (I63.9)

Cancer: _____
What type? _____

Others: _____

ALLERGIES: Including Seafood, IV dye, Local Anesthetic, Betadine, Chloraprep or Alcohol ❑NONE

DRUG/FOOD	TYPE OF REACTION		DRUG/FOOD	TYPE OF REACTION
1.			4.	
2.			5.	
3.			6.	

List ALL Current Medications Including blood thinners, over the counter, and herbals ❑NONE ❑See List

NAME	Dose/Day		NAME	Dose/Day
1.			4.	
2.			5.	
3.			6.	

PREVIOUS SURGERIES ❑NONE	
Procedure	**Year**
1.	
2.	
3.	

FAMILY HISTORY ❑NONE				
	Mother	**Father**	**Sister**	**Brother**
Mental illness				
Alcoholism				
Drug Abuse				

Tobacco use:	**❑Never**	**❑Use Now; Type & amount** _____	**❑Quit - when?** _____
Alcohol use:	**❑Never**	**❑Use Now; Type & amount** _____	**❑Quit - when?** _____
Illegal drug use:	**❑Never**	**❑Use Now; Type & amount** _____	**❑Quit - when?** _____

Is there any change that you are pregnant? ❑No ❑Yes ❑Unsure ❑N/A

Exposure to X-ray, ultrasound as well as taking or stopping medications during pregnancy and breast feeding can harm the baby. **Please notify the doctor if you plan to or become pregnant.**

Buprenorphine as well as other pain and nerve medications may affect your balance and ability to ambulate, drive or operate machinery. Upon initiating the medication and after every increase in dose, have a responsible adult in attendance, ambulate with caution and do not drive or operate machinery for a few to several days, until you know the medicine is not causing you to be sleepy, dizzy or clumsy, Also, your judgment, reflexes and reaction time may be slowed even in the absence of drowsiness, dizziness or impaired mental ability.