Sletten Wellness

INTEGRATIVE AND SPORTS MEDICINE

Welcome to Sletten Wellness Medical Center. We are honored and excited to be partnering with you in your medical care. For optimal time efficiency and productivity, it is imperative that you complete the New Patient Intake Form before your initial visit. Upon receiving the Intake Form, we will call you to schedule an appointment. You may send the form via mail, fax or personal delivery.

Also, please bring to your appointment the following:

- ☐ All Laboratory Tests with Results
- ☐ Any Special Imaging Study (e.g., X-Ray, MRI)
- ☐ All Medical Consultation Reports (e.g., Neurologist)
- ☐ All Developmental Assessments
- ☐ Complete Immunization Records
- ☐ Patient Insurance Card (for Laboratory Billings)

In order to have longer and higher quality interactions with our patients, Sletten Wellness is a fee-for-service practice. You will be expected to pay your bill in full at the time that you receive services. We accept Visa, MasterCard, check or cash.

We will provide you with an accurate superbill with a correct service level and diagnosis coding. You may submit this to your insurance company for reimbursement. If your insurance company requests, we will provide you with any clinical documentation at no charge so that your reimbursement is fair and appropriate. We will make every effort to assist you in this process.

Your initial time investment in compiling these records will greatly enhance the value of our time together and lead to a clearer strategy for treatment. Thank you for your diligence and commitment for greater health and we look forward to seeing you at Sletten Wellness Medical Center.

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NEW PATIENT QUESTIONNAIRE – Adult – Sports Medicine

Date:_____ Email Address(es):_____

Last Name:_____First:_____ Sex: M ☐, F ☐

Nickname:_____ Occupation:_____ # of Yrs. in School:____

Social Security Number (SSN):_____ Birth Date:_____

Marital Status: Married ☐, Divorced ☐, Widowed ☐, Separated ☐: (Number of Years):_____

Primary Address:

Street Address:_____ City_____ State____ Zip _____

Telephone:

Home Phone:_____ Mobile_____ Office_____

Others living in the home

Name:_____ Age:____ Relationship:_____

Name:_____ Age:____ Relationship:_____

Name:_____ Age:____ Relationship:_____

Pets:_____ Religion_____

How did you hear about Sletten Wellness?:_____

Primary Care Physician:

Name _____

Address_____

Phone _____ Fax:_____

Who should we contact in case of emergency?

Name:_____ Phone:_____

Relationship_____

Insurance Information:

Company Name_____ Phone_____

Address _____

Insured Name _____Group # _____ Policy #_____

Describe the reason for your visit today:_____

_____

_____

_____

_____

_____

_____

_____

Hospitalizations/Surgeries:

Year:	Illness:	Year:	Surgery:

Allergies to Medicines:

Allergies to Environment:

Allergies to Food:

Medications:

Name:	Dose:

Supplements:

Name:	Dose:

Physical Activity:

Type:	Frequency:	Type:	Frequency:

Habits:

Alcohol:_____ Type:_____ # of Drinks/day:_____ # of Drinks/week:_____
Cigarettes:_____ # of packs/day:_____# of years:_____ Years since quit:_____
Other recreational drugs and frequency: _____
Coffee/Teas:_____ # of cups/week_____ Caffeinated or Decaf_____

Social:

What do you do for fun/hobbies?_____
_____
_____

Nutrition History:

What was your primary staple growing up?_____
Do you have any food cravings?_____
_____

Provide a three-day representative diet journal:

DAY 1	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	
DAY 2	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	
DAY 3	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	

Family History: If you or someone in your family has experienced any of the items listed in the table below, circle the item(s), list nature of illness and which relative (please use abbreviations listed below):

Migraine	Learning disability	Asthma	Stroke	Chronic Fatigue
Epilepsy	OCD	Thyroid disease	Hypertension	Fibromyalgia
Neurologic Disease	Eating Disorder	Diabetes	Emphysema	Infectious Disease
Genetic Disease	Other mental illness	Anemia	Alcoholism	Hepatitis
Depression	ADD/ADHD/Autism	Bleeding Disorder	Drug Abuse	Peptic Ulcer
Bipolar	Glaucoma	Cancer	Other Addictions	Intestinal Disorder
Schizophrenia	Deafness	Lipid Disorder	Osteoporosis	
Anxiety	Allergy	Heart Disease	Auto Immune Disorder	

(Please describe and use reverse side if more space is needed)

Mom = Mother	F = Father	G = Grand	Self = Self
M = Maternal	P = Paternal	U = Uncle	
S = Sister	B = Brother	A = Aunt	
D = Daughter	Son = Son	C = Cousin	

Example: MGF = Maternal Grandfather

_____

_____

_____

_____

_____

Systems Review: (Circle all that apply and provide explanation)

Skin (Do you have or have you had any of the following):

Dry Skin	Acne	Rashes	Eczema	Psoriasis
Fungal Infection	Cellulitis	Dry Cracked Lips	Hives	Brittle Nails
Hair Loss	Herpes	Warts	Other (please explain):	

(Please describe and use reverse side if more space is needed)

_____

_____

_____

_____

Head & Neck: (Do you have or have you had any of the following):

Vision Problems	Eye Pain	Poor Night Vision	Hearing Problems	Ring in Your Ears
Ear Infections	Sinus Trouble	Congestion	Headaches	Dizzy Spells
Sore Throats	Dental Problems	Coated Tongue	Nose Bleeds	Hoarseness
Hayfever	Thyroid Disease	Swollen Glands	Canker Sores	Other Concerns

(Please describe and use reverse side if more space is needed)

_____

_____

_____

_____

Respiratory: (Do you have or have you had any of the following):

Chronic Cough	Asthma/Wheezing	Pneumonia	Pleurisy	Emphysema
Bronchitis	Shortness of Breath	If shortness of breath:	While lying flat?	In the last week?
Affects lifestyle?	Other Concerns			

When you exercise vigorously, are you limited by shortness of breath or by leg fatigue? (Please describe all of above):

_____

_____

_____

_____

Cardiovascular: (Do you have or have you had any of the following):

Chest Pain	High Blood Pressure	Abnormal Lipid Test	Heart Murmur	Swollen Ankles
Irregular Pulse	Rapid Heart Beat	Leg Pain	Cold Feet	Varicose Veins/Phlebitis
Heart Attack	Other Concerns			

Please describe and use reverse side if more space is needed)

_____

_____

_____

_____

_____

Gastrointestinal/Digestion: (Do you have or have you had any of the following):

Appetite Change	Difficulty Swallowing	Weight Changes	Heart Burn	Peptic Ulcer
Frequent Burping	Nausea/Vomiting	Gallbladder Problems	Jaundice	Hepatitis (A,B,C, Other)
Diarrhea	Constipation	Diverticulitis	Crohn's/Ulcerative Colitis	Hemorrhoids
Hernia	Abdominal Pain	Other Concerns		

(Please describe and use reverse side if more space is needed)

_____

_____

_____

_____

Stool Evaluation:

Frequency?_____

Do you have pain with bowel movement? _____

Do you feel bloated?_____

Describe stool by checking all that apply below:

Texture: Normal ☐, Hard ☐, Mushy ☐, Sticky ☐, Runny ☐, Visible Food Particles ☐

Color: Normal ☐, Pale ☐, Yellow ☐, Green ☐, Dark ☐, Black ☐, Bloody ☐

Odor: Normal ☐, Pungent ☐, Don't Know ☐, Other ☐ _____

_____

Genitourinary: (Do you have or have you had any of the following):

Overactive Bladder	Pain with Urination	Urgency to Urinate	Leakage	Decreased Flow/Force
Leakage with Exertion	Blood in Urine	Kidney Stones	Urine Infection	Kidney Disease
Prostate Problems	Bed Wetting	Other Concerns (list):		

(Please describe and use reverse side if more space is needed)

Musculosketal: (Do you have or have you had any of the following):

Broken Bone	Osteoporosis	Arthritis	Neck Pain/Injury	Back Pain/Injury
Gout	Disease of Muscle	Disease of Bone	Other Concerns	

(Please describe and use reverse side if more space is needed)

Miscellaneous: (Do you have or have you had any of the following):

Rheumatoid Arthritis	Vasculitis	Immune Deficiency	Lupus	Autoimmune Disease
Anemia	Bruise Easily	Blood Clotting Problem	Fatigue	Weight Gain/Loss
Excessive Sleep	Insomnia	Diabetes	Cancer	Pituitary Disorder
Metabolic Disorder	Adrenal Disorder	Measles	Mumps	Chicken Pox
Polio	Tuberculosis	Herpes	Aids/HIV Disease	Rubella (German Measles)
Lyme Disease	Meningitis			

(Please describe and use reverse side if more space is needed)

Neurology: (Do you have or have you had any of the following):

Seizures	Stroke	Tremor	Numbness	Headache
Migraines	Memory Loss	Localized Weakness	Tingling	Concentration Problems
Forgetfulness	Loss of Coordination	Guillain-Barré	Muscular Dystrophy	Concussion/Head Injury

(Please describe and use reverse side if more space is needed)

Females – *Please complete*

Do you have any of the following? If yes, please circle the item and describe below:

Abnormal periods	PMS	Menopause
Pain with sex	Pelvic Pain	Pelvic inflammatory disease (PID)

_____

_____

_____

Menstrual flow: Regular ☐, Irregular ☐, Pain/Cramps ☐. Days of flow_____. Length of cycle_____

Date of first day of last period_____. Pain or bleeding during or after sex_____

Number of pregnancies_____. Abortions_____. Miscarriages_____. Live Births_____

Birth control method(s)_____

Hot flashes/menopause ☐

Last PAP date:_____. Results:_____

Last mammogram date:_____. Results:_____

Environmental History:

Where were you born?_____

What was your primary location of residence during the following ages:

1 – 10 y.o. _____

10 – 20 y.o. _____

20 – 30 y.o. _____

> 30 y.o. _____

Do you have or have you had: Pesticide Exposure ☐, Chemical Exposure ☐, Radiation Exposure ☐, Toxic Occupational Exposure ☐. If yes, please explain:_____

_____

_____

Have you been tested for lead or heavy metals?_____

_____

Do you have any known chemical sensitivities? _____

_____

Mental Health:

How do you relax?_____

_____

What makes you:

Happy _____

Sad_____

Angry _____

Stressed_____

Have you had psychological counseling? If so, describe_____

Any problems with the following? If yes, please circle and describe.

Depression	Anxiety	Fears/Phobias	Thoughts of death	Decreased life enjoyment
Suicide	Mood Swings	Concentration	Attention	Work Performance
Social Interaction	Relationships	Learning Disorder	Antisocial Behavior	

(Please describe and use reverse side if more space is needed)

Additional Comments: