Music City
HEALTH CENTER

190D Saundersville Rd, Suite 3003
Hendersonville, TN 37075
615-265-8111

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Music City Health Center to release my personal medical information to me.

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Date of Birth: _____ **Spouse's name:** _____ **Phone:** _____

Your Occupation: _____

Emergency Contact: Name:_____ **Phone:**_____

Relationship:_____

In order of importance, list the health problems you are most interested in correcting:	**How long have you noticed these problems?**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____
4. _____	**4.** _____

1. **Name all of the doctors you have seen for these problems and what treatment you received:**

_____

_____

_____

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2. **Have your symptoms** (please circle one)**:** **Improved** **Worsened** **Stayed the same**

3. **Is this condition interfering with any of the following** (please circle all that apply):

Work Sleep Daily Activities Relationships Quality of Life

Mood Recreation Activities Mental Health

4. In the past, have you used birth control pills or taken antibiotics? _____

a. For how long?_____

5. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

6. How much sleep do you get each night on

average?_____

7. Do you have any food restrictions?

_____

_____

8. Do you smoke, drink, or use recreational drugs?

_____

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a. How much, how often? _____

b. How often do you drink caffeinated beverages?_____

9. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):_____

10. Are there foods that you eat on a daily or almost daily basis?_____

_____

a. Do you "miss" these foods if you do not eat them?_____

11. Write briefly about your weight gain/loss history:_____

_____

_____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

12. Please list close relatives that have diabetes, heart disease or obesity:_____

_____

13. What methods have you tried to lose/gain weight_____

_____

14. How is your energy level?_____

a. Are there times in the day that you feel best?_____**worst?**_____

15. Are you happy in your life right now?_____

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16. What are your main sources of stress_____

_____

17. How do you deal with your stress?_____

18. Next to each question assign a number between 0 and 10. You should assign values as follows:

0 = Not true, 1-2-3-4-5-6-7-8-9-10 = Very true

_____ <----------> _____

___ I have difficulty falling asleep.

___ I wake up throughout the night.

___ I frequently feel "wired" in the evenings.

___ I have energy highs and lows throughout the day.

___ I feel tired all the time.

___ I need caffeine to get going in the morning.

___ I usually go to bed after 10 pm.

___ I frequently get less than 8 hours of sleep per night.

___ I get fatigued easily.

___ Things I used to enjoy seem like a chore lately.

___ My sex drive is lower than it used to be.

___ I have been experiencing feelings of depression such as sadness or loss of motivation.

___ If I skip meals I feel low energy or foggy and disoriented.

___ My ability to handle stress has decreased.

___ I find that I am easily irritated or upset

___ I have had one or more stressful major life events (*i.e.*: divorce, death of a loved one, job loss, new baby, new job).

___ I tend to overwork with little time for play or relaxation for extended periods of time.

___ I crave sweets.

___ I frequently skip meals or eat sporadically.

___ I am experiencing increased physical complaints such as muscle aches, headaches, or more frequent illnesses.

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19. Check (√) off any of the following that have applied to you <u>within the last 30 days:</u>

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the U.S.?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

20. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

21. How often do you exercise?

_____

a. What is your workout regimen?_____

22. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____

23. Please list past surgeries, starting with most recent:

_____

_____

_____

24. Hospitalizations:_____

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25. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:			**Do you often:**		
Now	Past	**Satisfactory**	Now	Past	**Feel depressed**
Now	Past	**Boring**	Now	Past	**Have anxiety**
Now	Past	**Demanding**	**Do you often:**		
Now	Past	**Unsatisfactory**	Now	Past	**Have irrational fears**
Do you worry over:			Now	Past	**Feel upset**
Now	Past	**Home life**	Now	Past	**Feel things go wrong**
Now	Past	**Marriage**	Now	Past	**Feel shy**
Now	Past	**Children**	Now	Past	**Cry**
Now	Past	**Job**	Now	Past	**Feel inferior**
Now	Past	**Income**	**Have you:**		
Now	Past	**Money problems**	Now	Past	**Seriously considered suicide**
			Now	Past	**Attempted suicide**

26. Who is your primary care physician: _____

List ALL allergies/sensitivities to medication, food, and other items here:

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Item you react to:	Reaction:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name: _____Signature: _____

Date: _____