W E L C O M E

ABOUT YOU: Today's Date: _____

Name: _____

☐ **Male** ☐ **Female** Date of Birth __/__/__ **Age** ____ Height _____ Weight ____ SS# _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Education: # of years completed: _____ ☐ Student

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____ Who referred you? _____
Employed: ☐ Fulltime ☐ Part Time
Work Status: ☐ working without restrictions ☐ working with restrictions ☐ not working/off since _____

Home Phone #: _____ Work Phone #: _____ Job Description: _____

Employer Business Name: _____ Occupation: _____ Years Employed: _____

Employer's Address: _____
Street City State Zip Code

What is/are your presenting complaint(s)?
1. _____
2. _____
3. _____

EMERGENCY CONTACT INFORMATION:
Emergency Contact Person: _____
Phone #: _____ Relationship: _____

INSURANCE INFORMATION: ☐ Self-pay
☐ Please bill: ☐ Auto Insurance ☐ Worker's Compensation
Insurance Company ID #: _____ ☐ Health Insurance ☐ Other _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group #: _____ Subscriber's SS#: _____

Subscriber's Name: _____ Relationship: _____ Subscriber's Date of Birth: ____/__/____

Subscriber's Employer: _____

General Consent: I consent to evaluation and treatment. I understand that multiple treatment options exist, with varied risks and benefits, including drugs and surgery. I may choose not to receive any treatment and do nothing. If the risks and benefits of a proposed treatment/intervention are not clear, further information may be requested by me. I give full consent to receiving treatment, understanding that there are and many options and potential risks. Information within the patient chart is confidential. I understand that all requests for release of my records must be in writing and signed by me. I understand that I have a responsibility to communicate honestly to the Franktown Family Medicine health care team and notify them of any changes in my health status. If my condition is determined to be medically complex, or could benefit with specialty co-management, with the goal of improving clinical outcomes and efficacy, specialty referral will be made. I give full and unconditional consent that Paula Castro, MD manage, supervise or delegate care and bill me or my insurance for professional services rendered.

Financial Consent: I understand I am financially responsible for all charges incurred by me, whether or not my insurance pays. I assign my insurance benefits to Franktown Family Medicine-Paula Castro, MD. Any overpayment will be promptly refunded. I authorize Franktown Family Medicine-Paula Castro, MD to release protected health information to secure payment. Accounts over 90 days past due are subject to a monthly finance charge of 1.5%, 18% annually and collection costs.

Release of Records: I authorize _____ to release all health records necessary for my treatment and/or evaluation to Franktown Family Medicine/Paula Castro, MD.

Patient Signature _____ Date ____/____/_____

Responsible Party Signature (If patient is a minor)_____ Date ___ /_____/_____

Do you currently or have you had: Please mark all that apply

	Current	Past
Sleep Problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Irritability	☐	☐
Mood Swings / changes	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Growing moles or lumps	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Sinus infection	☐	☐
Motion sickness	☐	☐
Dental Problems	☐	☐

Date of last dental exam: _____

Do you currently or have you had: Please mark all that apply.

	Current	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Heartburn	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

Patient Name _____

Date _____

Do you currently or have you had: Please mark all that apply

	Current	Past
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding or bruising tendency	☐	☐

Do you currently or have you have: Please mark all that apply:

	Current	Past
High blood pressure	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Lung or breathing problems	☐	☐
Pneumonia	☐	☐

Do you currently or have you had: Please mark all that apply:

	Current	Past
History of trauma	☐	☐
Infection	☐	☐
Unexplained weight loss	☐	☐
Unusual fatigue	☐	☐
Dizziness / Poor balance	☐	☐
Vomit blood	☐	☐
Bloody or black stools	☐	☐
Change in appetite	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High blood pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Loss of bowel or bladder control	☐	☐
Headaches	☐	☐
Muscle weakness or paralysis	☐	☐
Memory loss	☐	☐
Severe trauma	☐	☐
Direct head trauma	☐	☐
Lost consciousness	☐	☐
Poor coordination	☐	☐
Night pain	☐	☐
Difficulty Swallowing	☐	☐
Recent infection	☐	☐
History of osteoporosis	☐	☐
History of cancer	☐	☐
Difficulty breathing	☐	☐
Abdominal pain	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
Use of birth control pills	☐	☐
Numbness in groin (saddle anesthesia)	☐	☐
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	☐	☐
Pain fails to improve with rest	☐	☐
Pain greater than 4 weeks	☐	☐
Prolonged use of corticosteroids	☐	☐
Intravenous drug use	☐	☐

ABOUT YOUR FAMILYHISTORY:
Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	**IF DECEASED, LIST CAUSE OF DEATH**
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT or WORK INJURIES **AREAS INVOLVED INDICATE TREATMENT**
(Please be as specific as possible) Year

1.
2.
3.
4.
5.
6.
7.

SERIOUS ILLNESSES: List **current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)**

1.
2.
3.
4.
5.
6.

Patient Name: _____ Date: _____

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS:	YES	NO	If yes, please describe:
Smoking	☐	☐	Packs per day: 0 – ½ ☐ ½ - 1 ☐ 2 or more ☐ Duration _____
Alcohol Consumption	☐	☐	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	☐	☐	Cups per day _____
Other Drug Use (Street Drugs)	☐	☐	_____
Exercise	☐	☐	Daily ☐ Weekly ☐ Monthly ☐ Type _____

HOBBIES OR INTEREST: _____

_____

_____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs

_____

_____

ALLERGIES: Please list all known allergies, especially to medicines. _____

_____

Treatment you are receiving or have received:

Medical care ☐ Chiropractic care ☐ Other ☐ _____

_____

Are you: Right handed ☐ Left handed ☐ Ambidextrous ☐

Do you currently or in the past have: Please mark all that apply

	Currently	Past (When, #episodes
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joints	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, hands or fingers	☐	☐
Numbness or pain in the legs, feet or toes	☐	☐

MALES ONLY

Do you have:

☐ Changes in urine stream ☐ Prostate trouble

☐ Lumps in testicles ☐ Erectile Dysfunction

Date of last Digital Prostate Exam:_____

FEMALES ONLY

Do you have:

☐ Menstrual problems ☐ Vaginal discharge

☐ Abnormal bleeding ☐ Tubal infections

☐ Breast lumps or pain ☐ Sex concerns

☐ Problems getting pregnant

Age periods began: _____

Number of pregnancies: _____

Number of miscarriages or abortions: _____

Number of Cesarean Sections: _____

Type of birth control: _____

Date of last gynecological exam: _____

Date last period began: _____

Are you currently or possibly pregnant? _____

Date of Last Mammogram_____

In general, how would you rate your health? ☐ **Excellent** ☐ **Average** ☐ **Poor**

What types of treatment are you interested in?:_____

_____

DOCTOR'S NOTES: _____

_____

_____

Patient Name: _____ **Date:** _____