Northview Wellness Center
4635 NE Stallings Dr, Ste. 106
Nacogdoches, Texas 75965
936-560-2405 ph. 936-564-3401 fax

Name _____ Date _____
Address _____City _____ State _____ Zip _____
Phone (____) _____ S/S #_____ Driver Lic. # _____
Age_____ Birth date_____ Sex_____ Status: M S W D # children_____
Occupation_____ Employer _____ Years Employed_____
Employer's Address_____ City_____State_____ Zip_____
Spouse's Name_____ Occupation _____Employer _____
Email Address _____ Race_____ Ethnicity: Non-Hispanic/Hispanic
Who referred you to our office? _____
What is your **major** complaint? (in detail)_____
_____
Other complaints _____
List you top five health concerns 1)_____ 2)_____ 3) _____ 4) _____ 5) _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? ____
What activities aggravate your condition? _____
Is this condition getting progressively worse? □ Yes □ No □ Constant □ Comes and goes
Is this condition interfering with you're: □ Family □ Hobbies □ Work □ Sleep □ Daily Routine?
Describe how you feel about this interference _____
When was the last time you felt really good? _____ Surgical operations? _____
Are you taking any medications? _____ Which ones? _____
Any non-prescription drugs? _____Which ones? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: □ M.D. □ D.C. □ D.O. □ D.D.S.
Doctor's Name _____ Diagnosis _____ Did it help? _____
X-rays/CT/MRI _____Urinalysis _____Blood Tests _____Other _____
Treatment: Medications_____ Physical Therapy _____
Were you off work? ___ How long? _____Did you return to the same job? ___ If not, why? _____
What else have you tried that has not worked? _____

HABITS

Currently Smoke? _____ How much? _____ Used to Smoke _____
When did you quit smoking? _____ Never smoked _____
Currently Drink Alcohol? _____ How much/often? _____ Used to Drink _____
When did you quit drinking? _____ Never drank alcohol _____
Currently Drink Coffee? _____ How much/often? _____
Currently Drink Soft Drinks? _____ How much/often? _____
Currently Drink Water? _____ How much/often? _____

ALLERGIES

Do you currently have any allergies? □ Yes □ No
Medication Allergies? _____
Food Allergies? _____
Grasses/Pollens? _____
Animals? _____
Other? _____

EXERCISE

Currently Exercise? _____ How often? _____ How do you exercise? _____
_____

FAMILY HISTORY

Illnesses on Mother's Side? _____ Who? _____ What? _____
Who? _____ What? _____
Illnesses on Father's Side? _____ Who? _____ What? _____
Who? _____ What? _____
Illnesses of Siblings? _____ Who? _____ What? _____
Who? _____ What? _____

INSURANCE INFORMATION:

Are you covered by Medicare? □ Yes □ No Medicare #_____
Do you have any group, union, or personal health and accident insurance? □Yes □ No
Name of Insurance Co. _____ Group # _____ Policy # _____
Address _____ Phone _____ Agent _____
Primary Insured's Birth Date _____ Primary Insured's SS# _____
Is your condition due to an accident or illness? □ Yes □ No □ Other _____

Secondary Insurance Co. _____ Group# _____ Policy # _____
Address _____ Phone _____
Primary Insured's Birth Date _____ Primary Insured's SS# _____

ACCIDENT INFORMATION: (Fill out if you were involved in a work, auto or personal injury accident.)

Did your accident occur while at work? □Yes □ No Were you involved in an auto accident? □ Yes □ No
Date _____Time_____Injury reported to employer? □ Yes □ No Supervisor _____
Description of accident _____
How were you injured? _____
Location of injury _____
Were you unconscious? Y/N □ Fractures □ Cuts □ Abrasions □ Bruises Work Restriction □ Yes □ No
Patient taken to _____ Hospital for _____ treatment.
Confined to hospital for _____ Days, _____ Hours. Name of hospital doctor: _____
Have you had any other personal injuries or accidents? □ Past year □ Past 5 years □ Over 5 years □ None
Describe: _____
Do you have an attorney? □ Yes □ No Name and Address: _____

Patient Signature: _____ Date: _____

Parental Consent to Treat a Minor

I hereby authorize Dr. Scott Sims and whomever he may designate as his assistants to examine and administer treatment as he so deems necessary to my child, _____.

Dated at Northview Wellness Center this _____day of _____ 20_____.

Signed: _____
Parent or Legal Guardian