



PARADIGM

HEALTH SYSTEM

A NEW DIRECTION IN HEALTHCARE

Patient Name: _____ Date: _____

Please complete this Questionnaire.

The purpose of this questionnaire is to obtain a thorough understanding of your medical status. Please accurately answer these routine questions before arriving for your appointment. This will result in more time allotted to your actual visit with the physician. We will not be able to see you in a timely manner without a completed questionnaire.

Reason for today's visit: _____

What is your age? _____ Height? _____ Weight? _____

PAST MEDICAL HISTORY:

High Blood Pressure/Hypertension	<input type="checkbox"/> No <input type="checkbox"/> Yes	Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Parkinson's Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Seizure/Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hypothyroidism	<input type="checkbox"/> No <input type="checkbox"/> Yes	COPD	<input type="checkbox"/> No <input type="checkbox"/> Yes
Migraine/Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Multiple Sclerosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Alzheimer's Dementia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Degenerative Disc Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Peptic Ulcer Disease (PUD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	GERD	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other: _____			

FAMILY HISTORY: (If other, please include paternal or maternal, if applicable)

High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
High Cholesterol	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Seizure/Epilepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Migraine	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Muscular Dystrophy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Parkinson's Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Multiple Sclerosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Alzheimer's Dementia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Other	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____
Other	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other _____

LIST ALL MAJOR SURGERIES:



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REVIEW OF SYSTEMS

CONSTITUTIONAL		MUSCULOSKELETAL	
Good general health lately	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Recent weight change	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint stiffness or swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Weakness of muscles or joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle pain or cramps	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Cold extremities	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Difficulty walking	<input type="checkbox"/> No <input type="checkbox"/> Yes
EYES		INTEGUMENTARY (skin)	
Eye disease or injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash or itching	<input type="checkbox"/> No <input type="checkbox"/> Yes
Wear glasses/contact lenses	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in skin color	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blurred or double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Varicose veins	<input type="checkbox"/> No <input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes		
ENT		NEUROLOGICAL	
Hearing loss or ringing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent or recurring headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nosebleeds	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lightheaded or dizzy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swollen glands in neck	<input type="checkbox"/> No <input type="checkbox"/> Yes	Convulsions or seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Numbness or tingling sensations	<input type="checkbox"/> No <input type="checkbox"/> Yes
CARDIOVASCULAR		PSYCHIATRIC	
Heart trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Memory loss or confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain or angina pectoris	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervousness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Palpitations	<input type="checkbox"/> No <input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of Breath with walking or lying flat	<input type="checkbox"/> No <input type="checkbox"/> Yes	Insomnia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swelling of feet, ankles or hands	<input type="checkbox"/> No <input type="checkbox"/> Yes		
RESPIRATORY		ENDOCRINE	
Chronic or frequent coughs	<input type="checkbox"/> No <input type="checkbox"/> Yes	Excessive thirst or urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spitting up blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat or cold intolerance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Asthma or wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes		
GASTROINTESTINAL		HEMATOLOGIC/LYMPHATIC	
Change in bowel movements	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding or bruising tendency	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nausea or vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rectal bleeding or blood in stool	<input type="checkbox"/> No <input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Abdominal pain or heartburn	<input type="checkbox"/> No <input type="checkbox"/> Yes	Past transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Peptic ulcer (stomach or duodenal)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
GENITOURINARY			
Frequent urination	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Burning or painful urination	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Blood in urine	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Incontinence or dribbling	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Kidney stones	<input type="checkbox"/> No <input type="checkbox"/> Yes		



Patient Name: _____ Date: _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

What is your occupation? _____

If you are disabled and/or retired, what was your occupation? _____

Highest grade level completed? _____

Are you currently a smoker? ☐ No ☐ Yes If yes, how many packs per day? _____
If yes, smoked since what age? _____

Are you a former smoker? ☐ No ☐ Yes If yes, when did you quit? _____

Do you drink alcohol? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Have you ever abused any of the following?

☐ Alcohol ☐ No ☐ Yes If yes, what kind? _____
☐ Prescription drugs ☐ No ☐ Yes

Have you ever used illegal drugs? ☐ No ☐ Yes If yes, what kind? _____

MEDICATIONS AND DOSAGE:

Medication	Strength	# of pills per day

MEDICATION ALLERGIES:



Patient Name: _____ Date: _____

ASSIGNMENT OF BENEFITS AUTHORIZATION FOR TREATMENT:

I authorize the providers of Paradigm Health System, L.L.C. to administer or perform medical treatment and/or services as they may deem necessary or reasonable. I further authorize Paradigm Health System, L.L.C. to release all information necessary to secure the payment of benefits and that benefits be made payable to the provider on my behalf or to myself.

I certify that I (or my dependent) have the insurance coverage that I presented and assign all benefits directly to Paradigm Health System, L.L.C. It is my responsibility to notify Paradigm Health System, L.L.C. of any changes in my health care coverage. I understand that I am financially responsible for all charges not covered by my insurance carrier, including any applicable deductibles, coinsurance and/or co-pay.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Please list below the names and phone numbers of those individuals who are permitted to discuss your care:

_____	_____
Name	Phone

_____	_____
Name	Phone

_____	_____
Name	Phone

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT.

Name of person signing below (print): _____

Signature: _____

Relationship to Patient: _____

Date: _____



Patient Name: _____ Date: _____

CANCELLATION POLICY

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We request that you give our office a 24 hour notice in the event that you need to reschedule or cancel your appointment. Our office takes the courtesy to call patients at least one day prior to their appointment as a reminder. If you cancel your visit the day of your scheduled appointment, or fail to show for your appointment without notifying our office, you may be billed.

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be canceled.

By signing this cancellation policy, you are indicating that you understand and agree to the terms explained above.

Patient's signature

Date