

# HOPKINS HEALTH & WELLNESS CENTER

## Health Consultation Form

Purpose of consultation:  Health Opportunity Consultation/Wellness Check-up  
 New Patient/New Injury

### Patient Information

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Street Address \_\_\_\_\_ PO Box \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Email address \_\_\_\_\_ SS # \_\_\_\_\_ Sex  Male  Female  
 Married  Single  Minor  Widowed  Divorced  Separated  Partnered  
Spouse's Name \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Patient's Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ Phone \_\_\_\_\_

### In Case of Emergency, Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

### Insurance Information

*A complimentary insurance verification is provided to assist in evaluating the financial responsibility of patients who choose to receive care and services at HHWC. Please provide a copy of your insurance card, and please fill out the information below regarding the primary policy holder:*

#### PRIMARY INSURANCE INFORMATION:

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder's Birth Date (if different from patient) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### SECONDARY INSURANCE INFORMATION: (if applicable)

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder's Birth Date (if different from patient) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

### Accident/Injury Information

Is your condition due to a recent accident or injury (within the last year)?  No  Yes, Date \_\_\_\_\_  
Type of accident:  Auto  Home  Work  Other \_\_\_\_\_  
Brief description \_\_\_\_\_  
To whom have you made a report of your accident?  Auto insurance  Employer  Worker Comp.  
 Other \_\_\_\_\_ Attorney Name (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

### Current Health Concerns

List your health care concerns: \_\_\_\_\_  
\_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  
 Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing  Walking  
 Bending  Lying down  Lifting  Other \_\_\_\_\_

Please mark on the diagram where you continue to have pain, numbness, or tingling.

