

# Millennium Medical

*Treating People, not Symptoms*

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## ENROLLMENT FORM

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name: \_\_\_\_\_  
First Middle Initial Last

Address: \_\_\_\_\_  
Number & Street City State Zip

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of last doctor appt.: \_\_\_\_\_ Dr. Name: \_\_\_\_\_

Do you have a Living Will? \_\_\_\_\_ Yes \_\_\_\_\_ No

How were you referred to our office: \_\_\_\_\_

Have you been injured in an accident?  Yes  No When? \_\_\_\_\_

Work Related?  Yes  No or Auto related?  Yes  No

Primary Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

# Millennium Medical

## New Patient History and Symptom Survey

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Why are you here today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### HEALTH QUESTIONS

#### Women's Health:

Last PAP \_\_\_\_\_ Last Mammogram \_\_\_\_\_ Last Colonoscopy \_\_\_\_\_

Last Dexa Scan \_\_\_\_\_ # of Living Children \_\_\_\_\_ Type of Delivery \_\_\_\_\_

Contraception \_\_\_\_\_ Last Menstrual Period \_\_\_\_\_ Cycle \_\_\_\_\_

Days of Flow \_\_\_\_\_ Quality \_\_\_\_\_ Age Menstruation started \_\_\_\_\_

Are you pregnant? \_\_\_\_ Yes \_\_\_\_ No If yes, what is your due date: \_\_\_\_\_

Problems: \_\_\_\_\_

#### Men's Health:

Breast Lump  Lump in Testicles Last Colonoscopy \_\_\_\_\_

Erection Difficulties  Penile Discharge/Sore  Prostate Problem

Problems: \_\_\_\_\_

#### Medical History:

High BP  Heart Disease  Diabetes  Stroke  Lung Disease  Stomach Disease

Surgeries: \_\_\_\_\_

\_\_\_\_\_

Family: Cancer      Diabetes      Heart      High BP      Respiratory      Mental

Mother                              

Father                              

Brother                              

Sister                              

#### Infectious Diseases:

HIV  Hepatitis  TB  HSV  Viral  STD

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies/Reaction: \_\_\_\_\_

\_\_\_\_\_

<b>Review of Systems (Mark all that Apply)</b>				
	<b>X</b>		<b>X</b>	<b>X</b>
<b>Constitutional:</b>		<b>Respiratory (Lungs):</b>		<b>Endocrine:</b>
Fatigue		Asthma		Muscle Spasm
Weight Loss		Wheezing		Frequent Thirst
Weight Gain		Short of Breath		Frequent Hunger
Fever		Chronic Cough		Hair Loss
Chills		COPD		Cold Intolerance
Loss of Appetite		Bronchitis		Heat Intolerance
Weakness		Pneumonia		<b>Blood / Lymph:</b>
<b>Integumentary:</b>		Emphyzema		Bruising
Skin sores		<b>Gastro:</b>		DVT's
Bruising		Diarrhea		Excessive Bleeding
Dry Skin		Constipation		Slow Clotting
Rashes		Indigestion		Swelling of Lymph Nodes
Moles		Hemorrhoids		Anemia
Skin Tags		Nausea		<b>Allergies:</b>
<b>Eyes:</b>		Vomiting		Hay Fever
Vision Changes		Blood in Stool		Food Allergies
Blurred Vision		Number of BM's per day		Animal Allergies
Double Vision		Poor Appetite		Seasonal Allergies
Glasses		Bloating		Post Nasal Drip
Contacts		Gas		Medication Allergies
Cataracts		Bowel Changes		Other Allergies:
Glaucoma		<b>Urinary:</b>		<b>Breast / Chest:</b>
Macular Degeneration		Incontinence		Breast Pain
Eye Disease		Urgency		Brest Mass
<b>Ears, Nose &amp; Throat:</b>		Stress Incontinence		Nipple leakage
Headaches		Blood in Urine		Breast Implants
Earaches		Dysuria		Breast / Chest Tenderness
Sore Throat		Frequent Urination		Nipple Discoloration
Sinus Problems		<b>Musculoskeletal:</b>		
Mouth Sores		Muscle Pain		
Cough		Muscle Aches		
Tooth Pain		Joint Pain		
Post Nasal Drip		Neck Pain		
Hearing Loss		Mid Back Pain		
<b>Cardiac (Heart):</b>		Low Back Pain		
Chest Pain		Knee Pain		
Palpitations		Shoulder Pain		
Chest Tightness		Other Pain:		
Angina		<b>Psychological:</b>		
Swelling - Leg		Depression		
Swelling - Ankle		Anxiety		
Swelling - Foot		Insomnia		
Previous Heart Attack		Excessive Sleep		
Heart Valve Disorder		Change in Sex Drive		
Pacemaker		Eating Disorder		

**Pain:**

Where is your pain? \_\_\_\_\_  
\_\_\_\_\_

What caused your pain and when did it start? \_\_\_\_\_  
\_\_\_\_\_

Is your pain:  Constant  Occasional  Moderate  Severe

Rate your Pain from 1-10 (1 being the mildest and 10 being the most severe) \_\_\_\_\_

What aggravates your pain? \_\_\_\_\_  
\_\_\_\_\_

What makes your pain subside? \_\_\_\_\_  
\_\_\_\_\_

Does your pain keep you awake at night or wake you up during the night? \_\_\_\_\_  
\_\_\_\_\_

Does your pain get progressively worse during the day? \_\_\_\_\_  
\_\_\_\_\_

Does your pain cause weakness in your arms or legs? \_\_\_\_\_  
\_\_\_\_\_

Does your pain radiate?  Yes  No If yes, where? \_\_\_\_\_  
\_\_\_\_\_

Have you had previous treatment for this pain?  Yes  No If yes, when and by whom?  
\_\_\_\_\_

What are your job duties daily? \_\_\_\_\_  
\_\_\_\_\_

What do you do for pleasure? \_\_\_\_\_  
\_\_\_\_\_

Does your pain interfere with your work or pleasure activities? \_\_\_\_\_  
\_\_\_\_\_

Do you exercise? \_\_\_\_\_

Are you seeking pain relief only or correction of the problem? \_\_\_\_\_  
\_\_\_\_\_

When was your last X-Ray taken? \_\_\_\_\_ What part of your body? \_\_\_\_\_

Have you had Chiropractic Care?  Yes  No

If so when \_\_\_\_\_ Dr. Name: \_\_\_\_\_

**Social History (Check all that Apply)**

<b>Marital Status</b>	<b>X</b>
Single	
Married	
Separated	
Divorced	
Widowed	
<b>Living Arrangements</b>	
Own home	
Rent home	
Live alone	
Does not live alone	
Children at home	
No children at home	
No children	
Have a will	
Have a living will	
Signed DNR	
Need other legal assistance	
<b>Education</b>	
Currently attending school p/t	
Currently attending school f/t	
Some High School	
High School Graduate	
GED	
Vocational School	
Some College	
College Graduate	
Graduate Degree	
Post Graduate Degree	
<b>Employment Status</b>	
Working full time	
Working part time	
Disabled	
Retired	
Not Working	
<b>Occupation/Exposure</b>	
Agricultural	
Construction	
Manufacturing	
Medical/Hospital	
Office Work	
Painter	
Salesperson	
Homemaker	
Other occupation	
Exposure to dust	
Exposure to noise	
Exposure to radioactivity	
Other Exposure:	

<b>Alcohol</b>	<b>X</b>
Never	
Rarely	
Daily	
Hard liquor 1-2 oz. per day	
Hard liquor over 3 oz. per day	
Beer: 1 bottle per day	
Beer: 2 bottles per day	
Beer: 3 or more bottles per day	
Wine: 1 glass per day	
Wine: 2 glasses per day	
Wine: 3 or more glasses per day	
In recovery	
<b>Smoking</b>	
Current every day smoker	
Current some day smoker	
Smoker	
Former smoker	
Never smoker	
Current status unknown	
Unknown if ever smoked	
Number of Years:	
Packs per day:	
Year quit:	
Does not use other nicotine products	
Uses the following nicotine product(s):	
<b>Caffeine Usage</b>	
Does not drink caffeinated beverages	
Drinks Coffee (cups per day)	
Tea (Cups per day)	
Pain relievers containing caffeine (Excedrin, etc)	
Caffeinated soft drinks (12 oz. per day)	
Energy drinks	
Caffeine supplements (No Doz, Alert, Vivarin, etc)	
<b>Substance Use</b>	
Never used	
Occasional use	
Regular use	
Amphetamines	
Cocaine	
GHB	
Inhalants	
LSD	
Cannabis	
MDA/Ecstasy	
Methamphetamine	
Opiates	
Pain medication	
PCP	
Sleep aids	
Steroids (anabolic)	
Received treatment for abuse	

<b>Diet</b>	<b>X</b>
Eat less than 3 meals per day	
Unrestricted diet	
Diabetic diet	
Low sodium diet	
Low carbohydrate diet	
Low fat diet	
Vegetarian diet	
Vegan diet	
Other diet:	
Use community services for meals	
<b>Exercise</b>	
Regularly	
Occasionally	
Rarely	
Never	
<b>Activities of Daily Living</b>	
Use a cane	
Use a walker	
Use a wheelchair	
Use a hearing aid	
Use a catheter for urine	
Aids are in good order	
Aids are not in good order	
Have problem using toilet	
Does not have problem using toilet	
Able to drive	
Unable to drive	
Rely on others for transportation	
Rely on public transportation	
<b>Lifestyles</b>	
Not sexually active	
Sexually active	
Partner opposite sex	
Partner same sex	
Partners both sexes	
Consistently use contraceptives	
Does not consistently use contraceptives	
<b>Foreign Travel/Living</b>	
Has recently lived outside of U.S.	
Has not recently lived outside of U.S.	
Has recently traveled outside of U.S.	
Has not recently traveled outside of U.S.	

**Mark all that Apply**

<b>Previous Treatment</b>	<b>X</b>	<b>Diagnostic Studies</b>	<b>X</b>
Nothing		X-rays	
Chiropractic Care		Head and/or Neck	
Acupuncture		Left Upper Extremity	
Injections		Right Upper Extremity	
Other:		Left Lower Extremity	
		Right Lower Extremity	
<b>Physical Therapy</b>		Chest	
Stretching		Cervical-Spine	
Strengthening		Thoracic-Spine	
Traction		LumboSacral Spine	
Iontophoresis/Topical Steroid		Pelvic	
Tens			
Massage		<b>Scans of the Body / Brain</b>	
Ultrasound		CT	
Heat/Ice		MRI	
Therapeutic Ball		PET	
		U/S	
<b>Medications</b>			
Muscle Relaxants		<b>Cancer Treatments</b>	
Pain Medications		Chemo Therapy	
Anti-Inflammatory (Prescription)		Radiation	
Anti-Inflammatory (Over the counter)			
		<b>Alternative Therapies</b>	
		Nutritional Medicine	
		Botanical Medicine (e.g. Herbal remedies, Chinese medicine)	
		Oxidative Medicine (e.g. HBO)	
		Hormone Balancing (e.g. Bioidentical hormone replacement)	
		Environmental Medicine (e.g. Detoxification treatments)	
		Energy Medicine (e.g. Acupuncture, yoga)	
		Physical Medicine (e.g. Chiropractic, massage therapy)	
		Other:	
		<b>Previous Blood Transfusion</b>	
		Yes	
		No	
		When:	
		Blood Type:	

