Juniper* Family *Medicine PLLC

Which Physician are you requesting? Laura Campbell Kate Pierce Amelia Ryan No Preference

Please complete questionnaire, in you do not have information to provide, PLEASE write N/A. Incomplete questionnaires ***will not be accepted.***

If you no- show your first appointment you will not be rescheduled.

Name First and Last:________________________________Date of Birth:___________________SSN:____________________

Email address:____ Previous name:____________________ F/ M

Home address:____City:____

State:_________________________Zip:_______________________Phone:________________Cell_____________________

Local Pharmacy:________________________________Address:____

Mail Order:____Phone:____________________________________

Insurance: ____ ID #_______________________________________

Policy Holder Name:__________________________Date ofBirth:________________________Relationship:____________

Employer:____Employer phone #_________________________________

Children living in home? ___________________________ ___________________________ ___________________________

Emergency Contact:______________________________________Phone number:___________________________________

HAVE YOU TAKEN ANY PRESCRIPTION MEDICATION ***FOR PAIN IN THE LAST 12 MONTHS***? Y/N

If yes please explain what and why ____

____

Do you suffer from any type of Chronic Pain? ***Y or N*** (circle one) if yes, please explain,______________________________

____

Current list of Medication: Attach addition sheet if needed.

1______________________________Dose__________________________ 2.______________________Dose_____________

3.______________________________Dose__________________________ 4.______________________Dose_____________

5.______________________________Dose__________________________ 6. ______________________Dose_____________

Allergies/intolerance and reactions to ALL medications.

1.________________________2.________________________3.________________________4.__________________________

Females only

Date of LMP__________________ Painful Periods Y/N

Current birth control method________________ Menses monthly Y/N

Last pap smear______________ History of abnormal paps Y/ N

Last Mammogram______________ Abnormal Mammogram Y/N

DEXA screening Y/N Taking calcium/vit D Y/N

FOR Men and Women

Date of Colonoscopy__________________________

Family History :(Please specify if paternal or maternal)

- *Relative* *Problem* *Died at age?*
- Paternal/Grandfather____
- Paternal/Grandmother____
- Maternal Grandfather____
- Maternal Grandmother____
- Father____
- Mother____
- Sibling____
- Children____
- Other____

Social History:

Smoking Status: (Circle which applies to you) Never smoke, Former smoker, When did you quit?___________

If you are a current smoker, how much do you smoke?_________ How many years have you smoked?______

Occupation? ____________________Employer________________________________

*Education:*_____________________Jr. High, GED, High school, some college, College Graduate, Post Graduate.

D*o you live alone or with others*?_________________________

Are you able to care for yourself? Y/N Single or Multi level home?_____________

Marital Status: Married- Single- Divorced-Separated-Widowed-Domestic Partner

Sexually Active: Y/N Protected sex? Always- usually- no

Have you ever been diagnosed with a STD? Which one?_____________

Do you exercise? None- Occasionally- Heavy Stress Level? None-Low- Medium- High

Alcohol intake: none 1-2 drinks/week 3-4 drinks/week 10 drinks/week

Rarely 1-2 drinks per month

Chewing Tobacco? None 1 per day 2-4 per day 5+ per day

Illicit drugs? Never, user, when I was younger

Do you use caffeine? None, 1-2 daily 3-4/day 5 or more per day

What type of diet do you follow? Regular , Vegetarian, Vegan, Paleo , How many times a week do you eat out?___

Guns in the home? Y/N Seat belts used routinely? Y/N Sunscreen Used? Y/N

Smoke alarms in the home? Y/N CO detectors in the home Y/ N

Do you have an Advanced Directive/ Living Will? Y/N PLEASE MAKE SURE WE HAVE A COPY IF YOU DO.

Do you see a Dentist regularly?   Y/N

Do you have difficulty doing any of the follow?

Concentrating, remembering or making decisions? Y/ N   Doing errors alone? Y/N

Dressing or bathing? Y/N   Driving at night? Y/N   Walking or climbing stairs? Y/ N

If you are a dependent, who is the primary caregiver?_________________________

Is it difficult to pay heat, water, or electricity bills? Y/ N

Do you have a consistent place to live? Y/N

Do you go hungry because you do not have enough food? Y/ N

Do you feel safe in your current living situation? Y/N

Do you have problems with transportation? Y/N

Patient Signature___________________________________Date__________________________________

By signing above you agree that the above information is true and correct. You authorize Juniper Family Medicine PLLC. to leave a voicemail on the phone number (s) above unless otherwise noted. Should there be any missing information: Juniper may refuse service. A NO SHOW FEE of $25 will be charged for a no show appointment. By signing this, I also acknowledge receipt of Juniper Family Medicine, PLLC HIPAA Privacy Act Policy. This indicates we participate with Colorado Prescription Monitoring Program and Quality Health Network which is a centralized data base for healthcare professional and authorize Rx prescription history consent. You are responsible for the balance: we will bill your insurance but if there is a deductible or co-pay it is due at the time of service.

There will be $150 new patient fee for anyone with a high deductible plan or insurance that cannot be verified the day of the appointment so please be prepared to pay at the time of service. This will be applied to your visit. ALWAYS bring your insurance card to EVERY visit. You must have a valid driver's license or photo ID to be seen.

Why do you need to be seen?____

Which physician is currently treating you?____________________________ Or who was the last physician to treat you?___________________________Why are you looking for a new physician?__________________________________

Accepted by: ______________________________________ Date: ______________________________