



7275 147TH Street West Suite 104 | Apple Valley, MN 55124

Phone: 651-333-9133 | Fax: 1-651-560-7013 | frontdesk@timewisemedical.com |

Patient Information:

Name: _____ Date of Birth: _____ Sex: M F
(First name) (Middle Initial) (Last Name)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Can we leave a detailed message? : Yes No

Email Address : _____

Employed: Yes No (if answered yes, please answer the following questions below)

Employer Name: _____ Employer Number: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information:

Emergency Name: _____ Relationship: _____
(First name) (Middle Initial) (Last Name)

Emergency Address: _____ City: _____ State: _____ Zip: _____

Emergency Phone Number: _____

Insurance Information:

Do you have health insurance? : Yes No (If answered yes, please answer the following questions below)

Patient's relationship: Self Spouse Child

Insured's Name: _____ Insured's Date of Birth: _____
(First name) (Middle Initial) (Last Name)

Insured's Phone: _____ Insured's Sex: M F

Insured's Address: _____ City: _____ State: _____ Zip: _____



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Are you allergic to any medication? Yes No (If yes, please list below)

Current Medication(s): _____

Past Medical History: (Please check all that applies)

- | | | | | |
|--------------------------------------|--|---|--|--------------------------------------|
| Diabetes <input type="checkbox"/> | Chest Pain/Angina <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Pacemaker <input type="checkbox"/> |
| Headache <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Cancer <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Heart Palpitations <input type="checkbox"/> | Stroke/CVA/TIA <input type="checkbox"/> | Seizure <input type="checkbox"/> |
| HIV/AIDS <input type="checkbox"/> | Stomach Ulcer <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Asthma/COPD <input type="checkbox"/> |
| Depression <input type="checkbox"/> | Heart Surgery <input type="checkbox"/> | Congestive Heart Failure <input type="checkbox"/> | Peripheral Vascular Disease <input type="checkbox"/> | |
| Blood Clots <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> | | |

Other: _____

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Grandparents: _____

Social History:

Marital Status: _____ Occupation: _____

Smoke: Never Ex-Smoker Current Smoker How many packs per day? _____

Alcohol: Never Occasional: Frequent

Additional Information: _____

Doctor's Signature: _____ Signature of Patient: _____



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New Patient Screening

Headaches: (If you do not get headaches please skip to the next section)

- 1) Do you have headaches on more than 15 days a month? **Yes** **No**
- 2) Do you take a treatment for headaches on more than 10 days a month? **Yes** **No**
 - a. If yes to question 2, did the treatment last for more than 3 months? **Yes** **No**

Depression: (If you do not have depression/get mood swings please skip to the next section)

- 1) Over the past couple of weeks, have you been restless/had disturbed sleep? **Yes** **No**
- 2) Over the past couple of weeks, have you been feeling unhappy/depressed? **Yes** **No**
- 3) Over the past couple of days, have you felt unable to overcome your difficulties?
(Problems of life that have been worrying you) **Yes** **No**
- 4) Over the past couple of weeks, have you been dissatisfied with the way you have been doing things?
(Things you have had to do at home or at work) **Yes** **No**

Neuropathic Pain: (If you do not get pain, please skip this section)

- 1) Do you suffer from a burning sensation? (e.g. stinging needles) **Yes** **No**
- 2) Do you have a tingling/prickling sensation in the area of your pain?
(e.g. crawling ants or an electrical tingling) **Yes** **No**
- 3) Is light touching (clothing, a blanket) in this area painful? **Yes** **No**
- 4) Do you have sudden pain attacks in the area of the pain? (e.g. electrical shocks) **Yes** **No**
- 5) Is cold/heat (bath water) in the area occasionally painful? **Yes** **No**
- 6) Do you suffer from a sensation of numbness? **Yes** **No**
- 7) Does slight pressure in the area (with a finger) trigger pain? **Yes** **No**
- 8) Does pain radiate to other regions of your body? **Yes** **No**
 - a. Please specify which regions of your body: _____