FRESH START MEDICINE
Where Your Recovery Begins

If this is your first visit with Fresh Start Medicine, how did you hear about us? Please be specific:

_____

Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Cell): _____

DOB: _____ Age: _____ SSN: _____-_____-_____

Email: _____

Gender: _____ Marital Status: _____

Emergency Contact (Required):

Emergency Contact Name: _____

Relationship to patient: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Insurance Information:

Name of Primary Insurance: _____

Policy Holder Name: _____ DOB: _____

Subscriber ID #: _____ Group #: _____

Name of Secondary Insurance: _____

Policy Holder Name: _____ DOB: _____

Subscriber ID #: _____ Group #: _____

Please complete the entire form and answer each question appropriately.

Current/Past Medical Conditions (circle all that apply):

Please place an "F" by any Family History of Conditions.

General:

- Night Fever/Chills
- Change in appetite
- General Weakness
- General Fatigue
- Frequent Nausea
- Fatigue

Integumentary:

- Skin Rash
- Changes in skin appearance
- Hair Changes
- Skin Cancer
- Easy Bruising
- Abscess

Head/Ears/Eyes/Nose/Throat:

- Bad Teeth
- Mouth Sores
- Nasal Discharge
- Hearing Loss
- Change in Vision
- Blindness
- Gum Disease
- Sore Throat
- Sinusitis
- Ear Drainage
- Eye Discharge
- Glaucoma

Cardiovascular:

- Infection in your heart (Endocarditis)
- Cardiac Arrest
- Heart Failure (CHF)
- Heart Murmur
- Arrythmia
- Heart Attack (MI)
- High Blood Pressure
- Palpitations
- Chest Pain (Angina)
- Rheumatic Fever

Respiratory:

- Bronchitis
- Emphysema
- Shortness of breath
- Lung Cancer
- Asthma
- Wheezing
- Tuberculosis
- COPD
- Pneumonia
- Chronic Cough

Please complete the entire form and answer each question appropriately.

Nervous System:

Anxiety Disorder	Depression	Insomnia
Bad Nerves	Chronic Headaches	Migraines
Tension Headaches	Brain Disease	Fainting
Blackout Spells	Numbness	Weakness
Paralysis	Alzheimer's	Meningitis
Spinal Cord Disease	Epilepsy	Seizures

Gastrointestinal:

Hepatitis	Liver Disease	Jaundice
Ulcers	Hernia	Reflux
Constipation	Diarrhea	Blood in stools
Irritable Bowel	Crohn's Disease	Ulcerative Colitis
Gallbladder Disease	Loss of bowel control	

Endocrine:

Type I Diabetes	Type II Diabetes	Pancreatitis
Thyroid Disease, high	Thyroid Disease, low	

Musculoskeletal:

Arthritis	Rheumatoid Arthritis	Osteomyelitis (Infection in the bone)
Bursitis	Artificial Joints	Osteoporosis (Low bone density)

Genito-Urinary:

Kidney Stones	Kidney Infection	Bladder Infection
Loss of control	Loss of control of urine	Kidney Failure
Low Kidney Function	Dialysis	

Hematology:

Taking Blood Thinners	Blood Clots
Easy Bleeding	Easy Bruising
Anemia	Abnormal Clotting
Hemophilia	Swollen Glands or Lymph Nodes
Sickle Cell Trait	Sickle Cell Disease

Please complete the entire form and answer each question appropriately.

Other Medical Problems:

1.	2.
3.	4.

Family History:

If there is any family history of the illnesses listed (Page 2-3), please put an "F" next to that illness.

Is there a family history of anything NOT listed? Please explain:

_____

Surgical History:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Childhood Illnesses:

Measles: Yes ☐ No ☐ Mumps: Yes ☐ No ☐ Chicken Pox: Yes ☐ No ☐

Medication Allergies:

Indicate the drugs that you are allergic to and what happens when you take it.

Drug Name	Side Effects/Reactions
1.	
2.	
3.	
4.	

Please indicate any other allergies you may have:

☐ Bee stings ☐Hay fever ☐Pollen ☐Grass ☐Dogs ☐Cats
Other_____

Please complete the entire form and answer each question appropriately.

Current Medications:

Please list all medications that you are **prescribed**, dosage, and how often you take it.

Medication	Dose	How Often Taken
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Social History:

Cigarettes: Now? Yes ☐ No ☐ In the past? Yes ☐ No ☐
How many per day on average? _____ For how many years? _____

Alcohol: Now? Yes ☐ No ☐ In the past? Yes ☐ No ☐
How much per day on average? _____ For how many years? _____

Other Providers:

Please list other providers that treat you. List their name, specialty, and phone/fax numbers:

1. _____
2. _____
3. _____
4. _____

Psychiatry: Have you ever been diagnosed with a psychiatric or mental illness? Yes ☐ No ☐

☐Antisocial ☐Schizophrenia ☐PTSD

☐Depression ☐Bipolar ☐Anxiety

Please complete the entire form and answer each question appropriately.

Past Mental Health Medications

If you have taken any of the following for mental health please check and fill in information

	Medication	Dose	Response Effect
☐	Medication		
☐	Airpazolam (Xanax		
☐	Amitriptyline (Eavil)		
☐	Aripiprazole (Abilify)		
☐	Brexiprazole (Rexulti)		
☐	Bupropion (Wellbutrin		
☐	Buspirone (Buspar)		
☐	Cariprazinhe (Vraylar)		
☐	Citalopram (celxa)		
☐	Clonazepam (Klonopin)		
☐	Clonidine		
☐	Clozapine (Clozaril)		
☐	Desvenlafaxine (Pristiq)		
☐	Diazepam (Valium)		
☐	Doxepin (Silenor)		
☐	Duloxetine (Cymbalta)		
☐	Escitalopram (Lexapro)		
☐	Exzopiclone (Lunesta)		
☐	Fluoxetine (Prozac)		
☐	Fluoxamine (Luvox)		
☐	Gabapentin (Neurontin)		
☐	Haloperidol (Haldol)		
☐	Hydroxyzine (Vistril)		
☐	Lamotrigine (Lamictal)		

	Medication	Dose	Response Effect
☐	Lithium		
☐	Lorazepam (Ativan)		
☐	Mirtazapine (Remeron)		
☐	Nortriptyline (Pamelor)		
☐	Olanzapine (Zyprexa)		
☐	Paliperidone (Invega)		
☐	Paroxetine (Paxil)		
☐	Prazosin (Minipress)		
☐	Quetiapine (Seroquel)		
☐	Risperidone (Risperdal)		
☐	Sertraline (Zoloft)		
☐	Temazepam (Restoril)		
☐	Topirimate (Topomax)		
☐	Valproic acid (Depakote)		
☐	Venlafaxine (Effexor)		
☐	Vilazodone (Viibyrd)		
☐	Ziprasidone (Geodon		
☐	Zolpidem (Ambien)		
☐	Oxcarbazepine (Trileptal)		
☐	Methadone		
☐	Naltrexone/Vivitrol		
☐	Buprenorphine		
☐	(Subutex, Suboxone		

Please complete the entire form and answer each question appropriately.