Ventura Wellness Group

Patient Information

Name____ Soc. Sec #_________________

Last First Initial

Address____

City_______________________ State_____ Zip________ Home Phone_________________________

Cell Phone________________________________ Email______________________________________

Date of Birth__________________ Sex □ M □ F □ Married □ Single □ Divorced □ Widowed

Patient Employed by____________________________________Occupation________________________

Business Phone____________________Notify in case of Emergency ____________________________

Who may we thank for referring you?____

Current Health Condition

Chief Complaint____

Other symptoms____

When did this begin?______________________ Have you had similar conditions in the past? □ Yes □ No

Was the onset □ Sudden □ Gradual □ Incident (describe)_____________________________________

Is condition getting □ Worse □ Better □ Same How often does this occur?_____________________

Have you received prior treatment for this condition? □ Yes □ No If yes, when and what type of care? _______

____

Health History

Prescriptions, supplements or over the counter medication you are currently taking______________________

____

Please list any serious injuries or surgeries you have had, including falls, head injuries or broken bones:

____

____

If you were in perfect health, what would be different about your life?_____________________________

____

Healthcare Providers

	Name	Phone	Recommend	May Contact
Primary Care	______________________________	____________	□	□
Specialist	______________________________	____________	□	□
Other Provider	______________________________	____________	□	□

Financial Responsibility

Payment is due when services are rendered, unless prior arrangement has been made.

Please speak with the Office Manager before seeing the Doctor if you have any questions or concerns.

Patient Authorization

Signed:__________________________________ Date:__________

MEASURE ACTIVITIES OF DAILY LIVING

Name: Signed: Date:

Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable
1 Self-Care, Personal Hygiene	Take a Shower				
	Take a Bath				
	Wash & Dry Body				
	Wash & Dry Face				
	Turn on/off Faucets				
	Brush Teeth				
	Get on/off Toilet				
	Comb/Brush Hair				
	Dress Self				
	Put on/off Shoes/Socks				
	Open carton of milk				
	Open a jar				
	Lift glass/cup to mouth				
	Make a Meal				
	Lift fork/spoon to mouth				
	Describe other: (bladder and bowl function difficulties: incontinence, constipation, etc.)				
2 Physical Activity	Stand				
	Sit				
	Recline				
	Rise from a chair				
	Get in/out of bed				
	Climb flight of 10 stairs				
	Work outdoors				
	Light housework				
	Shop/do errands				
	Carry groceries				
	Lift 5 lbs				
	Lift 10 lbs				
	Lift 20 lbs				
	Lift 30 lbs				
	Walk				
	Care for children or parents				
	Engage in hobbies:				
	Describe other: (eathing/chewing difficulty: TMJ?)				
3 Communication	Write a not				
	Type a message on a computer				
	See a television screen				
	Use a telephone				
	Speak clearly				
	Hear clearly				
	Discribe other:				
4 Non-Specified Hand Activities	Pick up small items				
	Turn a knob on a door				
	Write with pen/pencil				
	Steer wheel of car				
	Describe other:				

Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable
5 Sensory Function	Feel what you touch				
	Taste what you eat				
	Smell what you eat				
	Describe other:				
6 Travel	Get in/out of car				
	Drive a car				
	Ride in a car				
	Fly in an airplane				
	Ride a bicycle				
	Describe other:				
7 Sexual function	Engage in sexual activity				
	Describe specific difficulty: (Orgasm, ejaculation, lubrication, erection?)				
8 Sleep	Get to sleep				
	Sleep through the night				
	Have restful sleep				
	Feel refreshed after sleep				
	Describe specific difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.)