Health Quest Institute
Norman C. Neeb, D.O.

Health Quest Institute
Office of Dr Norman C Neeb, DO
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314-984-0033 314-485-8726 fax

# CONTACT INFORMATION

**Use Black Ink Only**

First Name _____ Initial___ Last Name_____

Gender _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Home Telephone ( ____)_____-_____ Cell (_____)_____-_____ Work (____)_____-_____

E-mail _____

Reminders for appts. Home Phone ☐ Cell Phone/TXT ☐ Work Phone ☐ E-mail ☐

Marital Status Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐

Occupation _____ Full/Part Time

Address _____

City _____ State _____ Zip Code _____

# EMERGENCY CONTACT

Name _____ Relationship _____

Home # (____ ) _____-_____ Cell (____)_____-_____ Work (____)_____-_____

Who referred you to Dr Neeb? _____

Is your condition related to personal injury and/or an accident where an attorney is involved? YES/NO
If yes, please explain

Your Primary Care Doctor's Name _____ Phone # _____

Your Primary Care Doctor's Address_____

May we contact your regular or referring doctor? _____

## Main Problem/Reason for this Visit: (If possible rank in order of importance to you)

When did this start? How did it occur?

_____

_____

_____

**Please describe your pain:** (check all that apply)

▢stiff ▢tingling ▢stabbing ▢pressure ▢constant
▢burning ▢tense ▢radiating ▢throbbing ▢other
▢shooting ▢sharp ▢dull ▢localized
▢achy ▢numb ▢tightness ▢intermittent

**What makes your complaint worse?**

▢Bending forward ▢Bending backward ▢Bending to the side ▢Twisting ▢Walking ▢Lying down
▢Coughing ▢Sneezing ▢Other_____

**What makes it feel better?** (check all that apply)

▢cold ▢rest ▢massage ▢lying down ▢medication
▢warmth ▢activity ▢quiet ▢standing ▢nothing

**What time of day do you feel the pain the most?**

▢morning ▢daytime ▢evening ▢night ▢all the time

**How physically demanding is your job?**

▢Light ▢Moderate ▢Heavy ▢Very Heavy ▢Not applicable

**Briefly describe your present job:**

_____

_____

**Additional Concerns/Problems you would like addressed?**

_____

_____

## Diagnostic Imaging: Check all that have been done for your main complaint(s)

| Anatomy | X-Ray | MRI | CT Scan | Bone Scan | PET Scan | EMG/NC |
|---|---|---|---|---|---|---|
| Head/Brain | | | | | | |
| Cervical | | | | | | |
| Mid Back | | | | | | |
| Low Back | | | | | | |
| Chest | | | | | | |
| Upper Extremity | | | | | | |
| Lower Extremity | | | | | | |
| Abdomen | | | | | | |
| Pelvic | | | | | | |
| Other | | | | | | |

**Have you had any tests/treatments/surgeries for these complaints? (Eg. Blood test, etc) <u>Please bring results with you and give them to the receptionist upon arrival.</u>**

_____

_____

_____

## Other Health Care Providers Seen

Have you seen an Osteopathic physician for a manipulative treatment prior to this visit? ☐ YES ☐ NO
If YES, please indicate with whom and approximate date_____
Was this visit related to your current complaint(s) ? ☐ YES ☐ NO
If YES, then what was the result of the treatments_____

Have you seen a chiropractor prior to this visit? ☐ YES ☐ NO

If YES, please indicate with whom and approximate date_____
Was this visit related to your current complaint(s) ? ☐ YES ☐ NO
If YES, then what was the result of the treatments_____

Have you seen a physical therapist prior to this visit? ☐ YES ☐ NO
If YES, please indicate with whom and approximate date_____
Was this visit related to your current complaint(s) ? ☐ YES ☐ NO
If YES, then what was the result of the treatments_____

## PAIN History

Circle the number on the line below that represents your pain at its least.

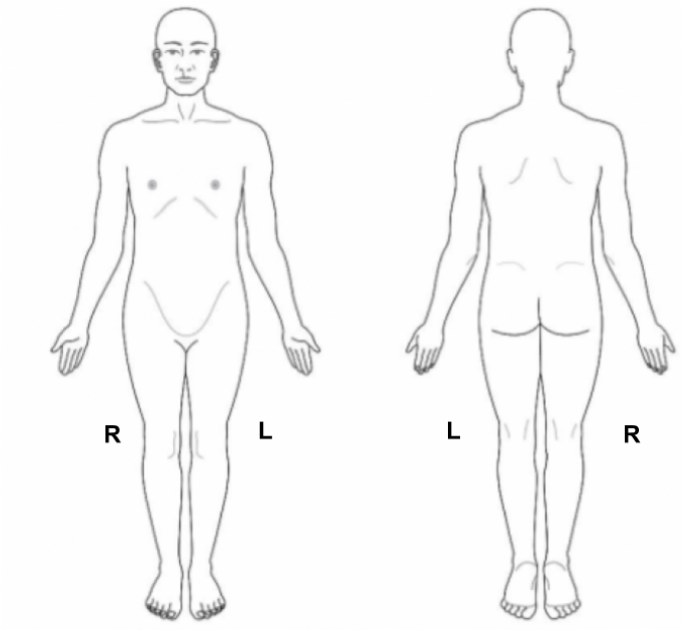
Circle the number on the line below that represents your pain at its worst.

Place an "X" on the line below that represents your pain right now.

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Severe Excruciating

Indicate Where your pain is located and what type of pain you feel at the present time. Use the symbols below to indicate the type. Only indicate pain that is related to your present complaint(s).

/// Stabbing
xxx Burning
ooo Pins/Needles
=== Numbness
+++ Aching




## Surgeries

| Date | Procedure | Date | Procedure |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Any scars NOT related to these surgeries?

## Significant Trauma History (falls, injuries, accidens, etc)

Date Description Date Description

_____ _____

_____ _____

## Allergies (medications, foods, environment) ▢No Known Drug Allergies

_____

_____

## Current Medications (use last page if necessary ) ▢ NONE

Name Dose Name Dose Name Dose

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

## Current Supplements ▢ NONE

Name Dose Times/day Name Dose Times/day

_____ _____

_____ _____

_____ _____

_____ _____

## Dental History

▢ TMJ ▢Dentures ▢Clenching/Grinding Teeth ▢ Night Guard/Oral Appliance

▢Crown/Bridge ▢Braces Age/Duration_____ ▢Retainer

## Devices- Do You Use:

▢Eyeglasses ▢Contact Lens ▢Hearing Aid ▢Brace (neck/back) ▢Pacemaker ▢Artificial Limb(s)

▢Orthotics Reason?_____ ▢ Dental Appliance ▢ CPAP_____

Other:_____

Handedness: R L Ambi

## Personal and Family History

Check off any issues/problems/diseases listed below. Self refers to the patient. Under Comment you can list the particular relative (father, sister, cousin, etc)

| | Self | Relative | Comment | | Self | Relative | Comment |
|---|---|---|---|---|---|---|---|
| Birth defect | ▢ | ▢ | _____ | Anemia/blood disorder | ▢ | ▢ | _____ |
| Premature birth | ▢ | ▢ | _____ | Cancer | ▢ | ▢ | _____ |
| Ear infections | ▢ | ▢ | _____ | Diabetes | ▢ | ▢ | _____ |
| Hearing problems | ▢ | ▢ | _____ | Thyroid | ▢ | ▢ | _____ |
| Eye/Vision issues | ▢ | ▢ | _____ | Growth issues | ▢ | ▢ | _____ |
| Rashes/Eczema | ▢ | ▢ | _____ | Endocrine/Gland | ▢ | ▢ | _____ |
| Sinus/Nasal | ▢ | ▢ | _____ | Growing panes/bones | ▢ | ▢ | _____ |
| Auto Immune | ▢ | ▢ | _____ | Scoliosis | ▢ | ▢ | _____ |
| Allergies | ▢ | ▢ | _____ | Neck/Back pain | ▢ | ▢ | _____ |
| Asthma | ▢ | ▢ | _____ | Arthritis/joint problem | ▢ | ▢ | _____ |
| Emphysema | ▢ | ▢ | _____ | Chronic pain | ▢ | ▢ | _____ |
| Pneumonia | ▢ | ▢ | _____ | Muscle problems | ▢ | ▢ | _____ |
| Tuberculosis | ▢ | ▢ | _____ | Swallowing problems | ▢ | ▢ | _____ |
| Chronic abdominal pain | ▢ | ▢ | _____ | Coordination issues | ▢ | ▢ | _____ |
| Chronic constipation | ▢ | ▢ | _____ | Headaches | ▢ | ▢ | _____ |
| Chronic diarrhea | ▢ | ▢ | _____ | Seizures | ▢ | ▢ | _____ |
| Gout | ▢ | ▢ | _____ | Memory issues | ▢ | ▢ | _____ |
| High blood pressure | ▢ | ▢ | _____ | Stroke | ▢ | ▢ | _____ |
| High cholesterol | ▢ | ▢ | _____ | Substance abuse | ▢ | ▢ | _____ |
| Hemorrhoids | ▢ | ▢ | _____ | Alcohol abuse | ▢ | ▢ | _____ |
| Liver disease | ▢ | ▢ | _____ | Depression | ▢ | ▢ | _____ |
| STD | ▢ | ▢ | _____ | Anxiety | ▢ | ▢ | _____ |
| Kidney disease | ▢ | ▢ | _____ | Other mental illness | ▢ | ▢ | _____ |
| Reflux/nausea/ Vomiting | ▢ | ▢ | _____ | Urinary infection | ▢ | ▢ | _____ |
| Other | ▢ | ▢ | _____ | Other | ▢ | ▢ | _____ |

**Diet** ▢ No known dietary allergies

Do you follow a particular diet? ▢No ▢Yes If Yes, what type/name _____

What do you typically have for

Breakfast_____

Lunch_____

Dinner_____

Snack_____

**Health Screening History** (list the date of the last exam)
Cholesterol_____ Blood Sugar_____ Other Blood tests_____

Blood in stool_____ Rectal exam_____ Colonoscopy_____

Immunizations: Polio_____ Tetanus_____ Hepatits_____ Pneumonia_____ Flu shot_____ Shingles_____

**Gynecologic History (Women only)**
Age of first menses____ Cycle length _____Pregnancies # ___ Births #___ Miscarriages ____
Date of last pap_____ Results _____ Breast Self Exam_____
Last mammogram/result_____
▢changes in sex drive ▢vaginal dryness ▢urinary incontinence ▢birth control _____
▢hormone therapy _____ Approx Date of Menopause _____

**Urologic History (Men only)**
Last prostate exam/result_____ Last PSA level_____ Self exam Tesitcles_____
Testicle exam professional_____
▢erectile dysfunction ▢changes in urinary flow ▢impotency

**Social History**
▢Single | ▢Married |▢ Partnered| ▢Divorced |▢ Widowed Who do you live with?_____

Children (Age and Gender)_____

Occupation_____

Job Satisfaction: ▢ Very Satisfied ▢ Satisfied ▢ Dissatisfied ▢ Worst Job Ever

What is your highest level of education?_____

Has anyone in your family been on Disability? ▢Yes ▢No

Is your home carpeted/hardwood/tile ? _____Pets _____

Check if you do any of the following in the past or now

▢Alcohol Age started_____ amount/day_____ Age quit_____
▢Caffeine Age started_____ amount/day_____ Age quit_____
▢Cigarettes Age started_____ amount/day_____ Age quit_____

▢Marijuana Age started_____ amount/day_____ Age quit_____
▢Illicit drugs Age started_____ amount/day_____ Age quit_____

▢Exercise Age started_____ amount/day_____ Age quit_____

Type of Exercise_____ How often?_____

_____How often?_____

_____How often?_____

Would you like to exercise again if you could? ▢ Yes ▢No
If Yes, doing what? _____

During the past month:
Have you had an anxiety attack (suddenly feeling fear or panic)? ▢Yes ▢No
Have you thought you should cut down on your drinking or drug use? ▢Yes ▢No
Has anyone complained about your drinking or drug use? ▢Yes ▢No
Have you felt guilty or upset about your drinking or drug use? ▢Yes ▢No
Was there ever a single day in which you had 5 or more drinks of beer, wine or liquor? ▢Yes ▢No

**Anything else you would like to tell the doctor?**

## Consent to Treatment and Terms

I _____hereby authorize Dr Norman C. Neeb, D.O. to administer such medical treatment as is necessary for a patient in my condition.

I hereby authorize Dr Norman C. Neeb, D.O. Inc. to furnish my insurance carrier(s), attorney, legal representative and referring and/or consulting healthcare providers all information concerning my present illness/injuries.

This office uses an outside billing management service (AMS- Associated Management Services)- Please direct all billing questions to this office at 314-432-2580

I understand that I am financially responsible for any charges not covered by my insurance and any charges incurred as a result of collection (i.e. attorney's fees, court costs and collection agency fees).

There is a $15 service fee for all CHECKS RETURNED BY YOUR BANK for any reason.

Appointment confirmation: I wish to be contacted for the confirmation of my appointments with the doctor by text message at (____)____-_____ By providing our office with this information, you authorize consent to be contacted by the above stated method. Health Quest Institute and Dr Norman C Neeb, D.O. are not directly charging you to receive these messages; however, standard message and data rates may apply from your phone provider.

CANCELLATION POLICY: If you need to cancel or reschedule an appointment please allow 24 hours in advance so that we may accommodate all patients in a timely fashion. Obviously, acute health problems, family or employment crises, and inclement weather are reasonable exceptions. Cancellations without 24 hours notice or no-show appointments will result in a $50 service fee that is not billable to your insurance. You will be reminded once if this initial explanation is forgotten. Then we will expect cooperation with future appointment changes. As always, we remain available to discuss these policies.

E-mail update consent: I wish to sign up for emails regarding patient treatment and care, surveys, promotions of services, etc at

_____

I understand I can opt out of these emails at any time.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits provided by the insurance carrier to Norman C. Neeb, D.O.

_____ _____

Signature of Patient or Guardian Date