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MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.  
VISION: TO REVOLUTIONIZE HEALTHCARE IN OUR COMMUNITY.

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## Welcome to Primary Care!

This questionnaire is for the purpose of getting to you know you better in order to provide the best possible Primary Care services. Please complete this form as honestly and completely as possible.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_

Any change in your personal information (i.e., address, phone number, marital status, etc.) from what we have?

Yes, there is a change (*please provide this information*)     No Change

Whom may we thank for referring you to primary care? \_\_\_\_\_

Why are you seeking care with us?     Pain     Wellness     Nutrition/Lifestyle

In your own words, what area(s) of your health are you concerned about?:

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How long has this been going on? \_\_\_\_\_

Have you missed work due to this condition?:     Yes     No

Have you had any previous tests, x-rays, CT scans, or MRI's previously taken?     Yes     No

What was done? \_\_\_\_\_ Where? \_\_\_\_\_

### **HIPAA Disclosure**

In an effort to maintain patient confidentiality and the guidelines within the HIPAA regulations, please fill out this section in regards to having someone other than you obtain information regarding upcoming appointments and/or information from your primary care/medical records, specifically.

I decline to give permission to a family member/friend.

I give permission to the following family/friend:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Ph #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Adult (PCP)