

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Type of Health Insurance: \_\_\_\_\_

Race: \_\_\_\_\_

Applied for slide: **Y** **N**

Date: \_\_\_\_\_

- 1) Do you have a previous or current medical provider? **Y** **N**  
 If yes, list their name and facility: \_\_\_\_\_
- 2) Have you seen a medical provider in the last year? **Y** **N**  
 If yes, please explain: \_\_\_\_\_
- 3) Have you gone to the emergency room for medical care in the last year? **Y** **N**  
 If yes, please explain: \_\_\_\_\_
- 4) Do you use special equipment or devices? **Y** **N**  
 If yes, please list: \_\_\_\_\_
- 5) Do you have a dentist? **Y** **N**
- 6) Have you ever been immunized or vaccinated? (example: tetanus shot, chicken pox vaccine) **Y** **N**
- 7) Do you regularly experience bodily pain that interferes with your daily activities? **Y** **N**
- 8) Have you/are you taking medications or treatments for pain? **Y** **N**  
 Who do you see? \_\_\_\_\_

9) Have you or anyone in your family ever been told that you have:

- High blood pressure
- Hepatitis
- High cholesterol
- Heart attack/disease
- Diabetes

10) Please list your current medications, dose, and prescribing provider if appropriate. Also include any over-the-counter medication, vitamins, or herbal supplements you are taking:

Medication	Dose	Provider

11) Please list any allergies you may have to medication, food, or pets, including seasonal allergies:

Cause	Symptom

12) How did you hear about us?

- Yellow pages
- Case Manager
- Online
- Valley Cache
- Friends
- Other: \_\_\_\_\_