515 Madison Ave, 6th Floor
New York NY 10022 (entrance on 53rd Street)
212-752-6770
212-754-0369
concierge@truwholecare.com
truwholecare.com/

Please enter your information.

First Name: | Middle Initials: | Last Name: | Date of Birth: | Gender:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone: | Email:

We confirm all patient appointments via email and text. Please indicate if you do NOT want to receive these reminders.

Name of Medical Insurance | Insurance ID number

Primary Care Physician: | Phone:

How did you hear about us?

- ☐ Existing Patient
- ☐ Facebook
- ☐ Referring Physician
- ☐ Instagram
- ☐ ZocDoc
- ☐ Internet Search

If Existing Patient, Name:

If Referring Physician, Name:

Occupation:

Employer's Name:

Emergency Contact: | Relationship: | Phone:

Pharmacy & Address: | Phone:

I am interested in the following medical & wellness services at Tru Whole Care (check all that apply):

- ☐ Internal Medicine
- ☐ Acupuncture
- ☐ Medical Massage
- ☐ Non-Surgical Orthopedics
- ☐ Nutrition/Weight Loss
- ☐ Counseling/Stress Management /Biofeedback
- ☐ Chiropractic
- ☐ Physical Therapy

I consent to treatment that is received in this office. I understand that my personal information is available to all medical providers at this location. I have received a copy of the office's notice of privacy practices and authorize the release of any medical or other information necessary to process a claim with my insurance. I received a copy of the patient financial responsibility form and agree to it. I request payment of insurance benefits either to myself or the party accepting assignment. I understand that I am responsible for any copay, deductible or expenses incurred that are not covered under my medical insurance.

Signature

_____ _____

Signature Date

What are your chief health concern(s)?

How did this issue begin?

Have you had this issue before? Were any diagnostic imaging (x-rays, CT, MRIs, etc.) or other tests performed?

Have you seen other doctors for this issue?

- ○ Yes
- ○ No

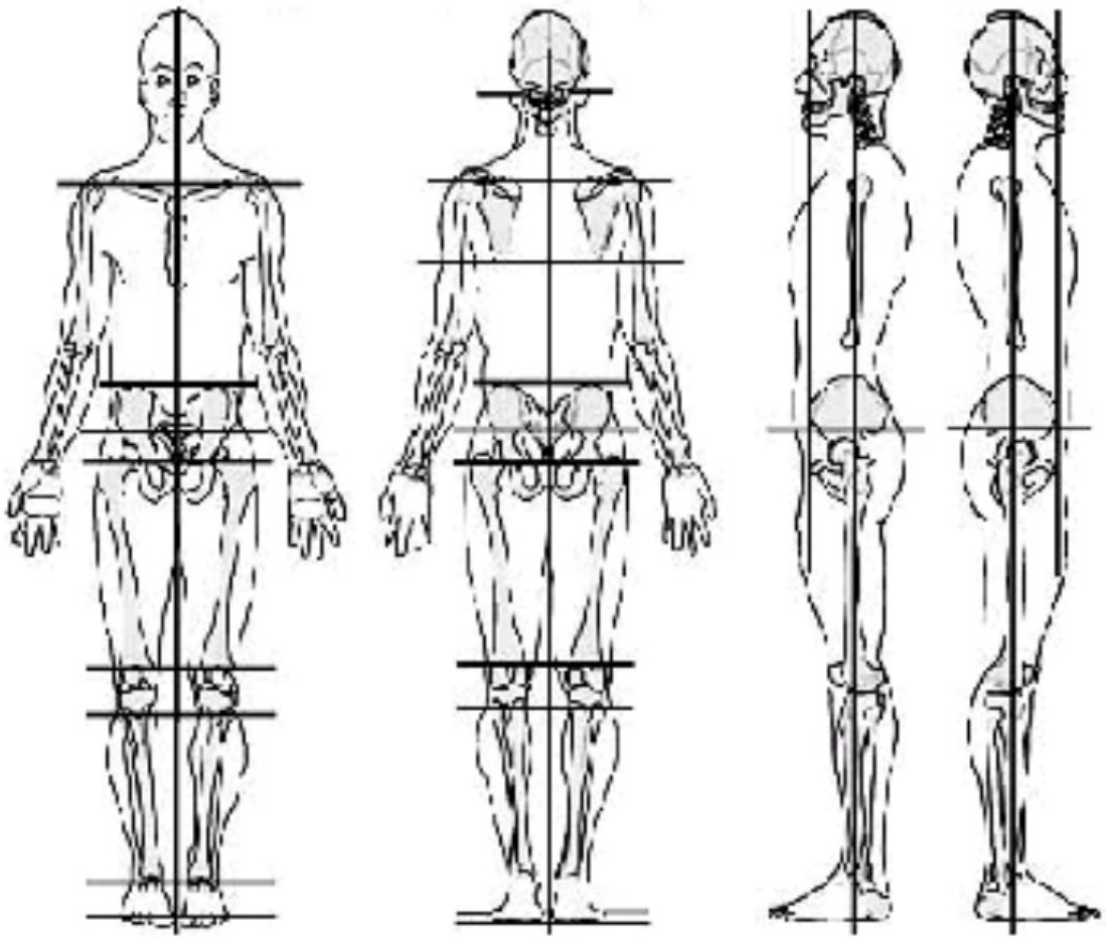
If so, please list the type of treatment received and the contact information for the other doctor(s):

Are you pregnant?

Who is your OB/GYN, doula and /or midwife?

For Physical Ailment as Primary Health Concern/Reason for Visit:

Circle the area(s) on the model if experiencing pain.



How bad is your pain or problem? (please circle; 0 = no pain, 10 = unbearable):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How is your lifestyle being affected due to the pain?

What time is the pain most severe? Least severe?

How would you describe the pain? (select all that apply):

- ☐ Aches
- ☐ Burning
- ☐ Gripping/Constricting
- ☐ Itching
- ☐ Sharp/Stabbing
- ☐ Soreness
- ☐ Tingling
- ☐ Weakness
- ☐ Dull
- ☐ Throbbing/Gnawing

What makes the problem better? (select all that apply):

- ☐ Cold
- ☐ Heat
- ☐ Inactivity
- ☐ Lying Down
- ☐ Movement
- ☐ Nothing
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Other

If other, please specify:

_____

What makes the problem worse? (select all that apply):

- ☐ Cold
- ☐ Heat
- ☐ Inactivity
- ☐ Lying Down
- ☐ Movement
- ☐ Nothing
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Other

If other, please specify:

_____

Height: _____ Weight: _____

FAMILY MEDICAL HISTORY

List any relevant or significant family medical history including relationship/ age of onset/diagnosis if known.

	Family Medical History	Relationship	Age of onset	Diagnosis if known
1				
2				
3				

PERSONAL MEDICAL HISTORY

Please list any relevant medical history, including surgeries (type/year), injuries, hospitalizations, illnesses with dates:

	Medical History	Dates
1		
2		
3		

Are you currently taking any medications or supplements/vitamins?

	Name/Type	Dosage	Frequency
1			
2			
3			

Please list any allergies (food allergies on following page) and type of reaction:

Exams/recent specialists seen

	Date
OB/GYN exam	
Dental exam	
Eye Exam	
Foot Exam	

SOCIAL HISTORY

In the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than Half the Days	Almost Every Day
Little interest/pleasure in doing things				
Feeling down, depressed or hopeless				

Do you practice meditation or mindfulness and if yes, how often?

Additional Information:

EXERCISE

Do You Exercise?

- ○ Never
- ○ Routinely
- ○ Occasionally

I exercise:

_____

Type of Exercise (check all that apply)

- ☐ Jogging/Running
- ☐ Stretching
- ☐ Walking
- ☐ Yoga
- ☐ Spin
- ☐ Barre
- ☐ Weights
- ☐ Other

If other, please specify:

_____

Additional Information:

_____

_____

_____

_____

DIET

Have you ever dieted?

- ○ Yes
- ○ No

If yes, at what ages?

_____

Do you have any food allergies/intolerances?

- ○ Yes
- ○ No

If yes, please list:

_____

_____

_____

_____

Have you met with a dietitian before?

- ○ Yes
- ○ No

If yes, for what reason(s)?

What goals would you like to accomplish by meeting with a registered dietitian?

Additional Information:

TOBACCO USE

Do you smoke?

○ Yes ○ No

I smoke:

#/Per Day: # Years: I quit smoking (mo/yr):

Additional Information:

ALCOHOL CONSUMPTION

Do you drink alcohol of any kind?

○ Yes ○ No

I regularly consume:

Additional Information:

Signature

Signature

Date