WESTERN VALLEY FAMILY PRACTICE, P.C.

PLEASE COMPLETE THE QUESTIONNAIRE IN FULL, IF YOU HAVE NO INFORMATION TO PROVIDE, WRITE "NONE" OR "N/A". INCOMPLETE QUESTIONAIRES WILL NOT BE ACCEPTED. PLEASE USE THE BACK IF ADDITIONAL ROOM IS NEEDED.

IF YOU NO-SHOW YOUR 1ST VISIT YOU **WILL NOT** BE RESCHEDULED.

Requesting Doctor:_____Male or Female **Facility:_____Redlands or Fruita_____**

How did you hear about us:_____ (PLEASE CIRCLE YOUR PREFERENCE)

PERSONAL INFORMATION					
Name:		E-Mail:		Race (optional):	
Date of birth:	Male or Female	SSN:		Phone:	
Alternate Phone:	Local Pharmacy:			Mail Order Pharmacy:	
Mailing Address:		City:	State:	ZIP Code:	
Physical Address		City:	State:	Zip Code	
Insurance Name:		ID#:		Policy Holder:	
Previous Physician:		Current Established Family:			
Emergency Contact:		Relationship:		Contact Phone:	

COMPLETE LIST OF CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS SEE BACK ☐ SEE ATTATCHED ☐					
1.	Dose:	2.	Dose:		
3.	Dose:	4.	Dose:		
5.	Dose:	6.	Dose:		
HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS FOR PAIN IN THE LAST 12 MONTHS? (Circle yes or no)				**YES**	**NO**
If YES, list Why, Medication, and Dose:					

CURRENT AND PAST MEDICAL HISTORY (PLEASE LIST) SEE BACK ☐ SEE ATTATCHED ☐			

Do you suffer from any type of Chronic Pain?	**YES**	**NO**	If YES, please explain.		
Do you have history of Substance or Alcohol Abuse?	**YES**	**NO**	If YES, please explain.		
Preventative Health Exams: Date of last:	Thorough health exam:		Pap Smear:	Mammogram:	Colonoscopy:

ALLERGIES/INTOLERANCE AND **REACTIONS** TO **ALL** MEDICATIONS AND OTHER KNOWN ALLERGIES SEE BACK ☐ SEE ATTATCHED ☐			
1.	Reaction:	2.	Reaction:
3.	Reaction:	4.	Reaction:

SURGICAL HISTORY AND DATE SEE BACK ☐ SEE ATTATCHED ☐			
1.	Date:	2.	Date:
3.	Date:	4.	Date:

HOSPITALIZATIONS AND DATE (INCLUDING PREGNANCIES) SEE BACK ☐ SEE ATTATCHED ☐			
1.	Date:	2.	Date:
3.	Date:	4.	Date:

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP – I.E. FATHER OR MOTHER – OR "N/A") SEE BACK ☐ SEE ATTATCHED ☐		
Diabetes:	High Blood Pressure:	Heart Disease:
Alcoholism:	Stroke:	Mental Illness:
Cancer:	Other:	

SOCIAL HISTORY (PLEASE ANSWER ACCORDINGLY OR WRITE YES OR NO) SEE BACK ☐ SEE ATTATCHED ☐					
Occupation/Employer:		Marital Status:	Sexually Active:	Religion:	
Do you Smoke?	Have you ever?	Packs per day?	How many years?	Year quit?	
Do you Chew?	Have you ever?	Cans per day?	Cans per week?	Year quit?	
Alcohol Use?	Have you ever?	How often?	Drug Use?	Do you use Marijuana?	Card?
Date of last vaccine:	Flu:	Tetanus:	Pnuemovax:	Hep B or A:	Shingles:

SIGNATURE	
Patient Signature:	Date:

By signing above you agree that the above information is true and correct. You authorize WVFP to leave a voicemail on the phone number(s) provided unless otherwise notated. Should there be any missing information, Western Valley Family Practice may refuse service. A No Show Fee of $20-$40 will be charged for all no show appointments. Also by signing this I acknowledge receipt of WVFP HIPAA Privacy Act Policy. This indicates we participate with Colorado Prescription Monitoring Program and Quality Health Network which is a centralized data base for healthcare professionals and authorize Rx prescription history consent. You are responsible for you balance; we will bill your insurance but if there is a deductible or co-pay it is due at time of service.