ALLEN KUO, D.O.
SELAH Healthcare Professionals, LLC

New Client Information

Patient:

Name:_____ Birthdate: _____Social Sec #: _____

Home Address: _____

City: _____State: _____Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Reason for Visit today:

_____

_____

Religious Affiliation: ☐ Yes ☐ No _____

Therapist / other mental health provider information: *(If applicable)*

May we contact this person in order to coordinate care? ☐ Yes ☐ No

Name: _____

Office Address: _____ City: _____ State: _____ Zip:_____

Office Phone #: _____ Fax #: _____

Primary Care Physician Information:

May we contact this person in order to coordinate care? ☐ Yes ☐ No

Name: _____

Office Address: _____ City: _____ State: _____ Zip:_____

Office Phone #: _____ Fax #: _____

ALLERGIES:(with reaction):

_____

_____

CURRENT MEDICATIONS/SUPPLEMENTS: (Please continue on reverse if needed)

MEDICATION NAME	DOSAGE	SCHEDULE (E.G. AM,PM)	REASON FOR MEDS

Medical Issues:

DIAGNOSIS	TREATING PHYSICIAN	YEAR DIAGNOSED

Inventory of Medical Wellness (please describe if there is an issue):

Eyes/Nose/Ears/Mouth/Throat: ☐ Yes ☐ No _____

Cardiac(Heart) issues: ☐ Yes ☐ No _____

Neurological issues (i.e. seizures, fibromyalgia, multiple sclerosis, etc.): ☐ Yes ☐ No

_____

Gastrointestinal (stomach) issues: ☐ Yes ☐ No _____

Previous Head Injury: ☐ Yes ☐ No _____

Musculoskeletal issues: ☐ Yes ☐ No _____

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Female issues (if applicable): ☐ Yes ☐ No _____

Male issues (If applicable): ☐ Yes ☐ No _____

Pulmonary (lung) issues: ☐ Yes ☐ No _____

Kidney/bladder issues: ☐ Yes ☐ No _____

Developmental Delay: ☐ Yes ☐ No _____

Alcohol/substance abuse: ☐ Yes ☐ No _____

Psychiatric Hospitalizations: ☐ Yes ☐ No _____

History or active self injury: ☐ Yes ☐ No _____

Attempted Suicide: ☐ Yes ☐ No _____

Eating Disorder issues: ☐ Yes ☐ No _____

Family History (please circle all that apply and note any extra ones not mentioned and family relationships below):

Diabetes, Seizure, Cardiac problems, high blood pressure, high cholesterol, auto immune disorders, cancer, Suicide, Depression, Bipolar Disorder, Attention Deficit Disorder, Anxiety, Panic Disorder, Autism, Developmental delays, Alcoholism and other substance abuse issues.

Family Relationships and other significant family history:

_____

_____

_____

Signature:_____

Signature *(guardian if under 18)*:_____

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For Patients that are under 18 years of age

Father

NAME:_____BIRTHDATE:_____

OCCUPATION_____

STREET
ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____

Mother

NAME:_____BIRTHDATE:_____

OCCUPATION_____

STREET ADDRESS (can list same as above):_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____
(can list same as above)

ARE BIOLOGICAL PARENTS (CIRCLE ONE): MARRIED ☐ DIVORCED ☐ SEPARATED ☐

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