Osteopathic Healing Hands, P.A
PAYEL BANIK, D.O.
2056 Sul Ross
Houston, Tx 77098
T:713-527-8499 F:713-588-8157

PATIENT INFORMATION FOR MEDICAL RECORDS

NAME:_____BIRTHDATE:_____
LAST FIRST

MAILING ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: ( )_____ WORK PHONE: ( )_____

CELL PHONE: ( )_____
EMAIL ADDRESS:_____ SEX:_____M_____F
FOR APPOINTMENT CONFIRMATION, WHICH NUMBER SHOULD WE USE?_____
EMERGENCY CONTACT:_____ PHONE:_____
EMPLOYER'S NAME:_____
MAY WE CALL YOU AT WORK?_____Y_____N
WHAT NAME DO YOU PREFERRED TO BE CALLED?_____
WHO REFERRED YOU TO DR. BANIK?_____
WHO IS YOUR PRIMARY PHYSICIAN?_____
WHO IS YOUR SURGEON?_____
WHO IS YOUR NATUROPATHIC PHYSICIAN?_____
WHO IS YOUR CHIROPRACTOR?_____

REASON FOR THIS VISIT:_____

NAME OF INSURANCE COMPANY:

NAME:_____

CONSENT FOR TREATMENT

I certify to the best of knowledge that the above information is correct. I hereby consent to Medical and Osteopathic Treatment for myself or my child/dependant.

SIGNATURE:_____ DATE:_____
RELATIONSHIP:_____SELF_____PARENT_____GUARDIAN

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PAYEL BANIK, D.O

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FINANCIAL POLICY

Welcome to our office.

We understand you have come here to seek specialized evaluation and care. We will do our best to assist your treatment process. To help you understand our office policies, please read the following and sign below. If you have any questions, ask our office staff for clarification.

All patients must complete our information form prior to see the physician.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DEBIT, VISA, MASTERCARD, AND DISCOVER

REGARDING INSURANCE

Our office does not accept insurance. You are responsible for all charges incurred as a patient in our office. Your insurance policy is a contract between you and your insurance policy. We are not a party to that contract policy. We will provide you with a superbill that you can submit to your insurance company as an out-of-network provider. In most cases you will be reimbursed directly from the insurance company for our services. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under medical insurance. **Please Initial_____**

For Medicaid and Medicare patients, we do not provide a superbill. **Please Initial_____**

MISSED APPOINTMENTS

Unless cancelled, **at least 24 hours in advance**, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. **Please Initial_____**
The patient is responsible for paying all collection fees, all collection costs, all attorney fees and all court costs, if such action is necessary, to settle a delinquent account.
Should there be any problem concerning financial agreements, please free to contact us and we will work with you to make a payment arrangement.

SIGNATURE:_____ DATE:_____

1. MAIN PROBLEM: What is the primary problem(s) you would like help with?

2. How long ago did this problem begin? (Please be specific)

3. Why do you think this problem occurred? What are your theories?

4. Are you worried this problem could be something serious?____Yes____No

5. To what extend does this problem interfere with your daily activities (work, sleep, play, sex, exercise)?

6. What kind of home treatments have you tried? What kind of self-care treatments have been helpful?

7. Have you seen any kind of health care practitioner for this problem? Please list names of any physicians, physical therapists, acupuncturists, or chiropractors

8. Have you been given a diagnosis for this problem?____Yes____No

9. Do you think that your current medical problem is due to something more serious than or different from what your doctors have told you?

   ____Yes____No____I don't know, I'm not sure
   If yes please explain:

10. Please list other current health problems (including physical, emotional, and social concerns).

11. Has there ever been an event, trauma, surgery, incident that has significantly or dramatically changed your life in anyway?

12. What are your goals in coming to see Dr. Banik at this time?

13. In general, how likely do you feel that this problem will be resolved or cured? **Circle of of the following:**

UNLIKELY	IMPOSSIBLE	CERTAIN	UNCERTAIN	LIKELY

14. In general, I'd describe my health as: **Circle of of the following:**

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR

15. **PAST SURGICAL HISTORY/OPERATIONS**

Have you had any of the following surgeries? **Please mark "x" for yes.**

Tonsillectomy:	Sinus Surgery of Drainage:
Adenoldectomy:	Wisdom Teeth Removed:
Hernia Repair:	Appendectomy:
Varicose VEin STripping:	Cosmetic Surgery:
Hemorrhoid Surgery:	Knee Surgery - Arthroscopic:
Surgical Implant:	Joint Replacement:
Spinal Laminectomy:	Orthopedic Surgery:

Men:	Women:
Vasectomy:	C-Section:
Prostate Surgery:	Tubal Ligation:

If you marked "x" (yes) to any of the above, please give the year._____

Have you had any other surgeries not mentioned above? If you have please list them below.

I have never had surgery.____Yes,____No. I have all my original equipment.

16. Have you ever had any fractures/broken bones? ____Yes,____No
    Have any fractures been set or fixed surgically? ____Yes, ____No
    Please list the bone(s) broken and the date:

17. Do you currently use a heel lift or shoe orthotic/insert? ____Yes,____No

18. Past Medical History/Illnesses
    Have you ever had any of the following medical illnesses:
    Please Mark "x" for yes

Heart Attack:	Stomach Ulcers:
Stroke:	Cancer of any kind:
Colitis:	Diabetes:
Kidney Disease:	Hepatitis:
Gastritis/ Stomach Inflammation:	Arthritis:

Do you have any other medical problems (current or in the past) not listed above? If yes, please mention below.

19. Have you ever had a head injury, concussion, forceful blow to your head at any time (from birth to date)? ____Yes,____No

If yes, please give the details of the incident and the dates.

20. Have you had a fall directly on your tail bone/sacrum? ____Yes,____No
If yes, please give the details of the incident and the dates.

21. When was your last dental appointment? Date:_____
Have you ever worn braces? ____Yes,____No
Do you currently use a brace or dental appliance for any reason? ____Yes,____No
Have you ever had any teeth extracted? ____Yes,____No

If yes, which teeth and when? _____

22. **X-RAYS/IMAGING HISTORY**
Have you had any of the following x-rays or imaging studies?
Please Mark "x" for yes

Chest X-Ray:	Upper GI/Stomach X-Ray:	Lower GI/Colon X-Ray:	CAT/CT Scan:
MRI Scan:	Back X-Rays:	Neck X-Rays:	Ultrasound Exam:
Bone Scan:	Arteriogram:	Echocardiogram:	Bone Density Test for Osteoporosis:

23. **Medication History**

A) Please list **all** prescription medications that you take on a ***daily or regular*** basis. This includes any medicine prescribed by a doctor (e.g. Thyroid, Blood Pressure RX, Pain Medicines, Sleeping Pills, Ulcer Medicines, Inhalers, Arthritis Rx, Creams, Premarin/Provera, Birth Control Pills, Prednisone, Glaucoma drops, etc…)
Please List Below

_____

_____

_____

B) Please list all prescription medication that you take on an as needed basis. This includes any medicine prescribed by a doctor. (e.g. Asthma Inhalers, Pain Medicines, Allergy Medicines, Nasal Inhalers, etc…)

Please List Below

_____

_____

_____

_____

24. C) Have you taken any of the following Over-the-Counter (OTC) medications in the past month for any reason?
Please Mark "x" for yes

Advil:	Antihistamines:	Laxatives:
Nuprin:	Decongestants:	Colace:
Motrin-IB:	Allergy Pills:	Senakot:
Ibuprofen:	Cold/Flu Medicines:	Exlax:
Alleve:	Nose Sprays:	Milk of Magnesia:
Naproxen:	Cough Medicines:	Ducolax:
Aspirin:	Antacids:	Citracil:
Excedrin:	Maalox/Mylanta:	Metamucil:
Bayer:	Tums/Rolaids:	Enemas:
Tylenol:	Alka Seltzer:	Fleets:
Acetomenphen:	Bicarbonate:	Primatene Mist:
Non Aspirin Pain Reliever:	Pepto Bismol:	
Orudis KT:	Anti Fungus Cream:	
Pepcid AC:	Cortisone Cream:	
Tagamet:		

-For any OTC medicine that you marked above with an X, please give more details as to when you take the medicine and how often:

Please List Below

_____

_____

_____

-Are there any other OTC medicines not listed above that you have taken in the past month?____Yes,____No

If yes, Please List Below

_____

_____

_____

_____

D) Please list **<u>all</u>** supplements, vitamins, minerals, herbs, or remedies that you take on a daily or regular basis ***(and explain the reason for taking each supplement/herb*)**.

Please List Below

_____

_____

_____

_____

E) Please list **<u>all</u>** supplements, vitamins, minerals, herbs, or remedies that you take on a needed basis ***(especially during the past 3 months)***.

Please List Below

_____

_____

F) Are you currently taking any Homeopathic remedies? ____Yes,____No

If yes, which remedy(s)?_____

Who prescribed them? _____

G) Do you have any true allergies to any medications?____Yes,____No
If yes, please list the drugs and reactions below.

_____

_____

H) Do you have any sensitivities (side effects other than allergies) to any medications?
____Yes,____No

If yes, please list the drugs and reactions below.

_____

25. My current height without shoes is: ____feet and ____inches.

26. My current weight is:____pounds.

27. To achieve a healthy body weight, I'd need to:
Please mark "x" for whichever applies, (A,B, or C) and answer.
____A. Lose about____pounds.
____B. Gain about____pounds.
____C. Maintain my current weight.

28. **Relationship/Marital Status:**

____Married
____Significant Other
____Previously divorced, now married
____Remarried
____Partner
____Spouse died, now remarried
____Single
____Widow(er)
____Divorced

29. If you are married or in a relationship, how many years have you been with your partner?____years.

30. Do you have children? ____Yes,____No
If yes, how many?_____

31. If applicable, do you have any grandchildren? ____Yes,____No
If yes, how many?_____

32. **Education:**

____Years of High School
____Years of College
____Years of Apprenticeship
____Years of Technical School
____Years of Postgrad/Professional School

____Other (please describe below)

_____

_____

33. Do you currently smoke cigarettes? ____Yes,____No

If yes, how many packs per day and for how many years total?

____packs, for____years

If yes, would you like medical help in stopping smoking? ____Yes,____No

34. Have you ever smoked cigarettes in the past? ____Yes,____No

If yes, when did you quit? ____years ago

How many years did you smoke? ____years

And how many packs per day did you smoke? ____packs per day

35. Do you drink alcohol? ____Yes,____No

If yes, how much daily:
____glasses of wine/day
____drinks/day
____cans of beer/day

If yes, how much weekly:
____glasses of wine/wk
____drinks/wk
____cans of beer/wk

36. If you answered **"Yes" to #34**, have you ever:

A) Felt the need to cut down drinking? ____Yes,____No

B) Felt annoyed by criticism of drinking? ____Yes,____No

C) Had guilty feelings about drinking? ____Yes,____No

37. Have you ever used alcohol to help ease a painful condition? ____Yes,____No

38. If you answered **"No" to #34**, have you ever had any problems with alcohol in the **past**?

____Yes,____No

39. **SLEEP HISTORY**

A) How many hours do you normally sleep? ____hours
B) How many hours of sleep do you need to function optimally? ____hours
C) Do you ever have trouble sleeping? ____Yes,____No
D) Do you suffer from insomnia? ____Yes,____No
If yes, please describe why and how often below.

_____

_____

E) Do you ever use sleeping pills? ____Yes,____No
F) Do you ever use alcohol to help you sleep? ____Yes,____No

40. Please list all your hobbies and recreational activities. Include: gardening, woodworking, art, sports,games, collections, etc.
Please List Below:

_____

_____

_____

_____

41. **STRESS HISTORY**

A) How does stress affect you? (physically/emotionally)

B) Do you currently have stress regarding your work, home life, relationships, or other areas of your life?

C) Do you have methods of reducing the effects of stress on your body or emotions? (I.e meditation, exercise, etc…)

42. **EXERCISE HISTORY**

In an average week, I participate in some form of aerobic exercise (the kind of exercise like jogging, bicycling, swimming, or fitness walking that increases my heart rate and gives cardiovascular fitness).

Please mark "x" for your answer

____**A.** Almost every day
____**B.** At least three times a week
____**C.** Maybe once a week
____**D.** My medical condition prevents me from participating in regular exercise

43. The type of aerobic exercise(s) I engage in most often is (are)...

Please mark "x" as many as apply below

____**A.** Walking outdoors
____**B.** Walking on a treadmill or stair climbing machine
____**C.** Jogging
____**D.** Swimming
____**E.** Aerobic dance
____**F.** Bicycling outdoors
____**G.** Stationary bike
____**H.** Social and/or folk dance
____**I.** Other:_____

44. In addition to aerobic, I regularly participate in:

____**A.** Weight lifting with free weights
____**B.** Weight lifting with weight machines
____**C.** Yoga (The Stretching type)
____**D.** Taichi
____**E.** Other:_____

45. **OCCUPATIONAL HISTORY**

Are you working now?

____**A.** Yes, I work in the home. (Full or Part Time?) _____
____**B.** Yes, I work outside the home. (Full or Part Time?) _____
____**C.** No, I am retired
____**D.** No, I've never been employed
____**E.** No, I'm not employed due to medical problems
____**F.** No, I'm on disability
____**G.** No, I'm out of work at this time
____**H.** No, I'm a full-time student

46. If you are not working at this time, are retired or not working for any other reason, please describe the type of work that you used to do.

_____

47. If you are a student, please briefly describe your course of study, the school you attend, and your future plans below:

_____

_____

48. Where do you work? _____
Name of company/employer:_____

49. What is your job title? _____

50. Please describe in detail the type of job you have. What are your duties, responsibilities, what do you do?
Please Describe Below:

_____

_____

_____

_____

51. If you work in the home, please describe your typical day.
Please Describe Below:

_____

_____

_____

_____

52. In addition to your regular job do you moonlight? ____Yes,____No
If yes, describe the type of work and how many hours per week.
Please Describe Below:

_____

53. How many total hours a week do you work on average? _____

54. Do you work: ____Indoors ____Outdoors ____Both

55. Does your job schedule require that you change shifts often? For example from day to night shift? ____Yes,____No

If Yes, Please Describe Below:

_____

_____

56. Do you use a computer? ____Yes,____No
How many hours per day? ____hours

57. Has medical illness or pain forced you to give up or change your type of work?
____Yes,____No

58. Have you ever missed work for the problem that you are currently seeing Dr. Banik for?
____Yes,____No

If yes, please describe in detail the injury or problem below:

_____

_____

_____

59. Have you ever had a workers compensation claim for any reason in the past?
____Yes,____No

If yes, please describe in detail the injury or problem below:

_____

_____

If there is any information not covered in this questionnaire that you would like Dr. Banik to be aware of, please add it here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please include all information you know of related to the following areas:

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age if living								
Age at death								
Cause of death								

Check any positive answer

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergy: Asthma Hives Eczema								
Hayfever								
Weight Problem								
Smoker								
Alcohol Abuse								
Mental Illness								
Cancer								
Diabetes								
Hyper-tension								
Heart Problem								
High Cholesterol								
Thyroid Disease								
Blood Disease								
Bowel Problem								
Ulcers								
Arthritis								
Migraines								
Other:								