CelebrityCare
MEDICAL CLINIC
Promoting Lifestyle Medicine

37131 IH-10, Suite 101 Boerne, Texas 78006
(830) 249-8400 Office (830) 255-4660 Fax

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

Patient Questionnaire

Patient Name ______________________ DOB ______________ Age ________
mm/dd/yyyy

Medical History – Please check if you or any blood relative has/had any of the following:

	You	Relative		You	Relative
Diabetes	☐	☐	Anemia	☐	☐
High/Low Blood Pressure	☐	☐	Alcoholism	☐	☐
Hepatitis/Liver Problems	☐	☐	Mental Illness	☐	☐
Heart Disease	☐	☐	Depression	☐	☐
Pulmonary Disease	☐	☐	HIV +	☐	☐
Kidney/Bladder Problems	☐	☐	AIDS	☐	☐
Arthritis	☐	☐	Blood Transfusions	☐	☐
Osteoporosis	☐	☐	Hearing Disorder	☐	☐
Heart Attack	☐	☐	Eye Disease	☐	☐
Stroke	☐	☐	Epilepsy/Convulsions	☐	☐
High Cholesterol	☐	☐	Recent Weight Loss/Gain	☐	☐
Stomach Ulcer	☐	☐	Migraine Headaches	☐	☐
Bowel Problems	☐	☐	Sinus/Throat Infections	☐	☐
Neurological	☐	☐	Angina/Chest Pains	☐	☐
Cancer (Type)	☐	☐	Any Other Disease (If yes, give details)	☐	☐

Any Unusual Family Illnesses ☐
(If yes, give details)

Are your immunizations current? Y N **Height** ________ **Weight** ________ **B/P** ________

Are you currently taking Medications?
(This includes prescription, non-prescription, vitamins and herbal preparations)

Medication	Dose	Times/Day	Medication	Dose	Times/Day

DRUG ALLERGIES

Drug	Reaction

Do You Now or Have You Ever Used:

Cigarettes? Y N ________ pk/day

Alcohol? Y N ________ glasses/week

Drugs of Abuse? Y N ________

Women: Is there any chance you may be pregnant?

Surgery: Have You Ever Had Surgery? (If yes, please give details)

Have you ever been advised to have any Surgical Procedure, which has not been done? **Y** (if yes, explain)

____

Signature ______________________ **Date** ______________
mm/dd/yyyy

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When entering phone numbers, social security number etc. below please enter numbers only. Do not enter dashes or other symbols.

PATIENT REGISTRATION FORM

Today's Date: ________________ _____ **New Patient** _____ **Updated Information**

Patient Legal Name: ____ **Age:**_______ **Date of Birth:** ____________
Last First Middle mm/dd/yyyy

Address: ____
Street or PO Box City State Zip Code

Hm. Phone # __________________ **Mbl #** __________________ **Other #** __________________

Email: ____

Marital Status: Single Married Divorced Widow Other **Sex:** Male Female

Social Security #______________________ **Driver's License #** ______________ **State**__________

Employer/School:______________________ **Occupation:**______________ **Work #** __________

Spouse/Parent's Name:______________________ **Hm#** ______________ **Wk#**______________

RESPONSIBLE PARTY: **(If other than patient): Relationship to Patient:**______________________

____
Name **Address** **City** **State** **Zip code**

____
Home # **Work #** **Occupation**

LOCAL PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:______________________ **Relationship**: ______________ **Phone #:** ______________

Address:____
Street or PO Box **City** **State** **Zip Code**

MEDICAL ARE: I authorize CCMC Providers or designee to provide myself or my dependent with reasonable and proper medical care according to today's standards.

Signature of Patient or Guarantor: ______________________________ **Date:**________________

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PATIENT INTAKE: MEDICAL FORM
(To be completed by patient)

Date: ____________________

Name: ____ DOB: _________________ SS# _________________________

Address: ____

Phone: (H) _______________________ (C) _______________________ Email: __________________________________

Marital Status: ___________________ Occupation: _______________________ Employer: _________________________

Emergency Contact/Relationship/Phone#: ____

Primary Care Physician/Phone #: ____

Date of Last Physical: ____________________________ Date of Last Menstrual Cycle: ______________________________

Childhood History (where did you grow up, # brothers & sisters): ____

____

Educational History: ____

Employment History: ____

Relationship/Marriage: ____

Children: ____

Current Living Arrangement: ____

Criminal Justice History: ____

Reproductive History (LMP, # of pregnancies): ____

CURRENT/PAST MEDICAL CONDITIONS
(Asthma, Hypertension, Liver/Thyroid/GI Disease, STDs, Cardiovascular, Seizure Disorder, Diabetes, Head Trauma, other)

CURRENT or PAST MEDICAL CONDITION	APPROXIMATE DATE OF ONSET OR DIAGNOSIS

PAST SURGERIES
(Gall Bladder removal, Appendectomy, Hysterectomy, Heart Surgery, Angioplasty, other)

PAST SURGERIES	APPROXIMATE DATE OF SURGERY

ALLERGIES
Medical/Environmental Allergies and Reaction: (Example rash, swelling, trouble breathing)

ALLERGIC TO	REACTION

MEDICATIONS
Please list any other medications you take that are not listed in the substance abuse patient questionnaire page (include any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia, ADD, ADHD or any other psychiatric illnesses).

MEDICATION NAME	DOSAGE/ FREQUENCY	PRESCRIBING PHYSICIAN	REASON TAKING MEDICATION

LIST PRIOR INPATIENT TREATMENT PROGRAMS INCLUDING OUTPATIENT TREATMENT PROGRAMS (IOP)

NAME OF PROGRAM	DATES	LENGTH

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

What is your longest period of (clean and sober) sobriety? ______________________________

What helped you remain sober? ______________________________

Do you have a family history of addiction? Yes No
If yes, who:______________________________

Do you have any current legal problems? Yes No
If yes, please describe:______________________________

Are you currently in a Pain Management Program? Yes No
If yes: Name of Program/Phone #:______________________________

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor?
If yes: Name/Phone #______________________________

Have you ever experienced, witnessed, or been confronted with traumatic events (abuse)? Yes No

Have you ever thought about, planned or attempted suicide? Yes No
If yes please explain (include dates): ______________________________

Are you currently suicidal? Yes No
If yes please explain: ______________________________

CURRENT SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

PAST SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

TOBACCO HISTORY

	HOW MUCH DAILY	HOW MANY YEARS	PAST/PRESENT
CIGARETTES			
SMOKELESS			
VAPE			

Have you ever experienced any of the following when you attempted to stop drinking or using? Please check all that apply.

	Seizures		Loss of Consciousness
	Tremors		Hot/Cold Sweats
	Nausea and Vomiting		Blackouts
	Hallucinations (DT's)		Falls

The consequences of drug use change over time. Initially, there is a "honeymoon" period in which few, if any, of the costs have time to emerge. But, as drug use continues the consequences begin to accumulate. In what way has your perception of benefits become overwhelmed by consequences?

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Monday, Tuesday & Thursday, 8am-4pm.

Before and after our scheduled office hours our answering service is available to answer your calls. The answering service cannot change nor cancel appointments. In the event your call is an emergency, please call 911 for assistance. Patients needing to reach the Physician or nurse during business hours for medication refills or general questions may leave a message on their voicemail. Messages are typically returned within 24 to 48 hours.

APPOINTMENTS– CCMC is committed to providing continuous coverage and quality care to our patients. Please be prepared to provide updated demographic and insurance information when scheduling an appointment and medication count.

All patients must notify the office **830-249-8400** of any appointments/cancellations within **48 hours** of their scheduled appointment. Failure to notify the office will be charged a **fullpayment** assessed to your account. **(Office staff will give a courtesy call – but is not required). $25 for EARLY REFILLS before your schedule appointment.**

(TEXTINGPHYICIANSFORMEDICALQUESTIONSORCONCERNSWILLBE CHARGED $25 TEXT)

TRANSFEROFCARE– We are happy to forward your medical records to your new provider should you choose to seek care with another Physician.

FINANCIAL OBLIGATION: It is our office policy to collect payment from patients at the time services are rendered. This includes any outstanding payment that was required after hours services as stated in your financial contract with our clinic. We accept cash, and credit cards. **We do not accept Insurance or Medicare/Medicaid**. On your behalf as a courtesy, we will provide you with an Invoice to submit for your insurance company for you to file the claim.

FORMS/LETTERS/MEDICAL RECORDS – A minimum of **a $75.00 fee will be applied to the completion of forms or letters requested by our office.** Extra charge over 50 pages (**25¢**). **Paymentisduewhenyoucollectthecompletedforms/letters.** FMLA paperwork or other forms require a 7-business day turnaround for completion**. (NO CHECKS)**

DRUGTESTING: IF YOU ARE SELECTED FOR A DRUG TEST YOU ARE REQUIRED TO COME IN THE SAME DAY! **NO SHOW IS A POSITIVE.**

Signature: ______________________________ Date: ____________________