Wake Sleep, LLC

3100 Duralelgh Rd, Ste 302 Ralelgh, NC 27612-8105
919-645-9280 (p) 919-208-2149 (f)

Name: _____ DOB: _____ Age: _____

Referring Physician: _____

Current Medications: _____

Allergies/ Adverse Drug Reactions (please list the side effects also) _____

Reason for Visit/ Referral _____

Is the reason for your visit due to an accident? *Yes No If yes, was it a motor vehicle accident? Yes No Work related? Yes No*

When did problem start? _____ If injury related, Date of Injury _____

Medications or treatments you have tried for your problem _____

Have you ever had a *Sleep Study?* Yes No If yes, When? _____ Where? _____

Are you Diabetic? Yes No Do you have a pacemaker? *Yes No* Have you ever been on seizure medications? *Yes No*

Females only: Are you currently pregnant? Yes No If No, Birth Control? Pills IUD Tubal ligation condoms other _____

Past Medical History: Please circle all that apply to you and your immediate family. (Mother, Father, Brother, Sister or Grandparent)

	Patient	*Family*						*Patient*	*Family*					
Anemia:	yes	M	F	B	S	GP	*Heart Failure:*	yes	M	F	B	S	GP
Arthritis:	yes	M	F	B	S	GP	*High Blood Pressure:*	yes	M	F	B	S	GP
Asthma / COPD:	yes	M	F	B	S	GP	*Irregular Heart / Palpitations:*	yes	M	F	B	S	GP
Cancer:	yes	M	F	B	S	GP	*Kidney Disease:*	yes	M	F	B	S	GP
Diabetes:	yes	M	F	B	S	GP	*Narcolepsy:*	yes	M	F	B	S	GP
Epilepsy/Seizures:	yes	M	F	B	S	GP	*Respiratory Failure:*	yes	M	F	B	S	GP
Erectile Dysfunction	yes						*Sleep Apnea:*	yes	M	F	B	S	GP
Headaches/: Migraines	yes	M	F	B	S	GP	*Sleeping Difficulties:*	yes	M	F	B	S	GP
Head Injury/ Concussion:	yes	M	F	B	S	GP	*Stroke:*	yes	M	F	B	S	GP
Memory Loss:	yes	M	F	B	S	GP	*Thyroid Disorder:*	yes	M	F	B	S	GP
PTSD:	yes	M	F	B	S	GP	Other: _____	yes	M	F	B	S	GP

Surgical History: _____

Social History:
Work Status: *full-time work out of work due to health/pain part-time work working with limitations retired unemployed*
Exercise? *Yes No how often? _____ Type: _____ Do you use Tobacco? Yes No Former Smoker quit date: _____*
Alcohol beverages: *Yes No #____drinks per _____ quit date: _____*
Any current or past drug use/abuse? *Yes No No #____times per _____ quit date: _____*

Review of Systems (Circle any that currently or recently apply to you)

Pain Type: burning aches dull sharp pounding	General: fatigue fever chills weight loss/gain	Eyes: dry eyes light sensitivity double vision blurred vision loss of vision	E, N, M, T: ringing in the ears hoarseness hearing loss swallowing difficulties
Cardiovascular: chest pain leg swelling irregular heart beat/palpitations	Respiratory: chronic cough shortness of breath wheezing	Skin: rashes hair changes	Lymph/Blood: enlarged nodes easy bruising / bleeding
Gastrointestinal: abdominal pain constipation diarrhea vomiting jaundice bowel incontinence	Genitourinary: frequent urination urgency pain with urination blood in urine bladder incontinence erectile dysfunction	Musculoskeletal: joint pain chronic back pain muscle pain muscle cramps/ spasms neck pain neck stiffness	
Neurological: chronic headaches numbness tingling memory loss involuntary movements speech difficulties tongue or cheek biting twitching or jerking passing out seizures arm / leg weakness loss of balance dizziness	Sleep: daytime sleepiness snoring insomnia wake up gasping for breath restless legs stop breathing at night violent dreams erectile dysfunction	Psychiatric: anxiety depression mood changes traumatic event paranoia hallucinations thoughts of harming yourself or others	

Wake Sleep, LLC

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Patient Information:

Patient Name: _____ DOB: _____

SS#: _____ Sex: Male / Female

Address: _____

Phone #'s: (home) _____ (cell) _____ (work) _____

E-Mail: _____ Preferred method of contact: Home/Cell/Work/E-mail

Is it ok to leave Appointment / Medical Information at this number? Yes No

Primary Insurance: _____
Subscriber: _____
Group #: _____ Subscriber ID: _____
Subscribers DOB: _____ SS#: _____
Relationship to patient: _____

Additional Insurance: _____
Subscriber: _____
Group #: _____ Subscriber ID: _____
Subscribers DOB: _____ SS#: _____
Relationship to patient: _____

Emergency contact: Name: _____ Relationship: _____ Phone #: _____

Is it ok to release Medical Information to this person? (Please circle) yes no

Other Persons Authorized to receive Medical Information: yes no

Name _____ Relationship _____ Phone #: _____

Marital Status: Married / Divorced / Single / Separated

Race: Caucasian/ African American / Asian / Native American / Hispanic / Other

Preferred Language: English/ Spanish/Other _____

Pharmacy/Location: _____

Address: _____ Phone #: _____

I _____ (patient name) give permission for Wake Sleep, LLC to give medical treatment. I have the right to **discuss all** medical treatments with my provider. I have the right to refuse any procedure or treatment.

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. I **give permission** to Wake Sleep, LLC to disclose my/the patient's health information to insurer to receive payment. I realize that I am **responsible** for all charges, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements **have been** made in advance.

In the event my account becomes delinquent, I understand I am responsible to pay actual and reasonable collection charges and/or attorney **fees.**

The undersigned hereby authorizes Wake Sleep, LLC to release all information pertaining to patient's treatment to his/her **insurance company** or companies and to any other physician or health care provider to whom the undersigned may be referred. **I hereby** assign all medical benefits for services provided, to which I am entitled, including medical, private insurance, and other **health plans** to Wake Sleep, LLC

I was offered and/or given the Notice of Privacy Practice. Initial: _____