Integrative Medical Specialists, LLC®
Trusted Partners in Alternative Care

WELCOME

Thank you for trusting Integrative Medical Specialists with your health care needs. We take our commitment to you and your family very seriously. We look forward to establishing a partnership that will enhance your health and well being; now, and well into the future.

We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule. For this reason, we've taken steps to assure that your time in our clinic is as focused and efficient as it can be.

Enclosed you will find new patient information forms. Before your scheduled appointment, please read and complete the attached forms. These forms are our first introduction to you, as a patient. Your detailed and thoughtful responses will help us to utilize our time in the clinic more effectively. **Please bring all forms, completed and signed, to your first office visit.**

Your first visit will be a thorough assessment of your health and may last up to 1 hour or more. Our fees vary based on the time and complexity of your case. This office is a cash office and payment is expected at the time of your visit. For your convenience, we accept cash, debit cards, Visa, MasterCard, American Express, Discover, Flex Spending and Health Savings Account cards. We do not accept checks.

Integrative Medical Specialists requires a $100.00 deposit for initial visits. We have many new patients who would like to be seen by our office and we make every effort to schedule each one as soon as possible. When someone fails to keep a new patient appointment without prior notice, we are unable to schedule someone else in that time slot.

We have found that financial commitment keeps no shows and last minute cancellations to a minimum. It is our policy to require a deposit of $100.00 to hold your appointment. A credit or debit card number will be required when scheduling your appointment. The deposit amount will be applied to your charges at the time of the initial visit. On the initial visit the minimum charge is $175 for a 30 minute consultation. After the first 30 minutes, the consultation rate is $87.50 per 15 minutes. Time needed is determined by the complexity of the case and the amount of time needed to teach the lifestyle changes. Our goal is to provide the most effective treatment and prevent future health risks with lifestyle intervention.

We require 48 hours notice to cancel or reschedule an initial visit. If the visit is canceled prior to 48 hours your deposit will be refunded. If your appointment is not canceled or rescheduled prior to the 48 hours, your deposit will not be refunded or applied to your initial visit. If you have previously scheduled and lost your deposit, a new deposit will be required upon rescheduling your initial appointment.

Please remember to bring in copies of any recent lab work, imaging reports, and recent medical records, as well as the bottles of supplements or medications you are currently taking.

We look forward to seeing you in our clinic. Our goal is to become a trusted partner to you and your family in your health care needs.

Sincerely,

Integrative Medical Specialists

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PATIENT DEMOGRAPHICS

Name _____ _____ _____/_____/_____
(Last) *(First)* *(Middle)* *(Sex)* *(Date of birth)*
Perm. Address_____ City _____ State _____ Zip _____
Temp. Address_____ City _____ State _____ Zip _____
Phone Perm (_____)_____ Cell Phone (_____)_____ Work Phone(_____)_____
E-Mail Address _____
(Notification of sales, specials, and new products and services will be sent by e-mail.)

As these are not considered "secure" communication devices:
Is it acceptable for us to contact you via e-mail? **YES / NO**
Is it acceptable for us to leave a message on a voicemail / answering machine for you? **YES / NO**
Is there anyone else that you would like us to contact regarding your patient information? **YES / NO**
If yes: Name _____ Number (_____)_____

How did you hear of us?
Yellow pages _____ Newspaper _____ Radio/TV _____ Internet _____ Sign _____
Were you referred by another physician? **YES / NO** Other: _____
If "YES", could you provide us with as much information as possible for the Referring Physician?
Referring Physician's Name _____
Address, City, State, Zip _____
Telephone Number _____

ADDITIONAL PATIENT INFORMATION

Today's Date _____/_____/_____ MD Physician _____
Employer _____ Occupation _____
Work Address_____ City _____ State _____ Zip _____
Name of nearest relative not living with you _____ Relation _____ Phone (_____)_____
Marital Status (circle) Single Married Separated Divorced With Partner Widow(er)
Name of Spouse (or parent for minor child) _____
Whom may we contact in case of an emergency _____
Relationship to you _____ Emergency Contact # (_____)_____

Name of Patient/Guardian _____ Date _____
Sign
Name of Patient/Guardian _____ Relationship _____
Print

Financial Policy

Thank you for trusting Integrative Medical Specialists where we are committed to providing the best health care possible. The following statement explains our financial policy. Please read the policy, sign and return to us prior to your treatment. Payment is due at the time services are provided. All supplements, health products, services and labs sales are final. We gladly accept cash, debit cards, Visa, MasterCard, American Express, Discover, Flex Spending and Health Savings Account cards. We do not accept checks.

Consultations

On the initial visit the minimum charge is $175 for a 30 minute consultation. After the first 30 minutes, the consultation rate is $87.50 per 15 minutes. Phone consults are also charged at this rate. Time needed is determined by the complexity of the case and the amount of time needed to teach the lifestyle changes. Our goal is to provide the most effective treatment and prevent future health risks with lifestyle intervention.

Insurance Coverage and Reimbursement

Naturopathic Medicine may be covered by some PPO plans as an out of network provider. By not billing insurance directly, this allows us to keep cash prices as low as possible, and to provide the best care for each patient without restrictions from the insurance provider. Please check with your insurance company to determine if this is a covered benefit. Integrative Medical Specialists does not submit billing claims. For those with out of network benefits, a superbill will be provided with billing codes to send attached to a claim form provided by your insurance company.

Laboratory and Diagnostic Testing

Due to everchanging guidelines from insurance companies, we will now be ordering all bloodwork through the discounted cash pay option with Quest Diagnostics. A form will be provided to those who wish to submit for insurance reimbursement. There is no guarantee that labs will be reimbursed by your insurance. Flex spending and health savings can be utilized to pay for these testing services.

Specialty labs such as comprehensive stool analysis, micronutrient testing, food sensitivity testing, heavy metal/essential element testing, hormone testing, etc. are also provided at cash pay discount rates. Flex spending or health savings can be utilized to pay for these specialty testing services, as well.

Prescribed Supplements

Supplements prescribed by the doctors are tax free and may be purchased with a HSA or Flex Spending Account. Your doctor can provide your HSA or Flex Spending plan with a letter of medical necessity. To purchase supplements through Flex Spending and HSA plans, follow up visits are required annually to authorize supplement and nutrient refills necessary for ongoing treatment.

Missed Appointments

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy for established patients. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a $100.00 fee for the appointment.

Consent to Treat

I consent to the use and/or disclosure of my protected health information by Integrative Medical Specialists for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my health care provider is a Doctor of Naturopathic Medicine. I understand and agree that diagnosis or treatment of me by Integrative Medical Specialists and my doctor may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Integrative Medical Specialists. I have read and agree to the financial policy. As the child's parent or guardian, I understand that I am consenting for the child to be treated.

Please request a copy of our Privacy Practices if you have any questions or concerns.

I UNDERSTAND AND AGREE THAT INTEGRATIVE MEDICAL SPECIALISTS IS A CASH OFFICE. I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE TIME OF EACH OFFICE VISIT. THIS INCLUDES ALL NATUROPATHIC THERAPIES, SUPPLEMENTS, OFFICE VISITS, LABORATORY CHARGES AND HEALTHCARE PRODUCTS. I UNDERSTAND THERE IS NO GUARANTEE THAT SERVICES SUBMITTED TO INSURANCE WILL BE REIMBURSED.

Name of Patient/Guardian _____ Date _____

Print

Name of Patient/Guardian _____ Relationship _____

Signature

Integrative Medical Specialists, LLC®
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CANCELLATION POLICY

At Integrative Medical Specialists, we continually focus on quality control and providing excellent customer service. We are unique in the services we offer, as we focus on correcting and preventing imbalances in the body and patient education for a healthy lifestyle. This lifestyle medicine approach requires in depth assessments that many times result in more lengthy office visits than typical doctor's appointments.

In order to provide excellent customer service, we strive to operate with efficiency. Our goal is to run on time for all our patient's appointments. **We request that all patients arrive at least 15 minutes prior to their scheduled appointment time.** This allows us to get any paperwork, updated information and test results organized and ready for your visit. If you are running late for your appointment, please call to see if we can accommodate a later appointment time. Out of respect for other patients, we may have to reschedule your appointment.

New Patient Deposit

Integrative Medical Specialists requires a $100.00 deposit for initial visits. We have many new patients who would like to be seen by our office and we make every effort to schedule each one as soon as possible. When someone fails to keep a new patient appointment without prior notice, we are unable to schedule someone else in that time slot.

We have found that financial commitment keeps no shows and last minute cancellations to a minimum. It is our policy to require a deposit of $100.00 to hold your appointment. A credit or debit card number will be required when scheduling your appointment. The deposit amount will be applied to your charges at the time of the initial visit.

We require 48 hours notice to cancel or reschedule an initial visit. If the visit is cancelled prior to 48 hours your deposit will be refunded. If your appointment is not canceled or rescheduled prior to the 48 hours, your deposit will not be refunded or applied to your initial visit. If you have previously scheduled and lost your deposit, a new deposit will be required upon rescheduling your initial appointment.

Cancelling and Rescheduling Return Visits

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy for return visits. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a $100.00 fee for the appointment.

I HAVE READ AND UNDERSTOOD THIS POLICY.

Name of Patient/Guardian _____ Date _____
Sign

Name of Patient/Guardian _____ Relationship _____
Print

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INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the doctors of Integrative Medical Specialists to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: i.e. Laboratory bloodwork, radiology, diagnostic imaging, thermographic imaging, thermometry, allergy testing, environmental testing, hormone testing, ES Teck lifestyle screening, and other specialty labs.

Physical Examination: Screening physical exams may include any of the following: skin & dermatology; head, ear, eyes, nose & sinuses & throat; face & neck; lungs & pulmonary; chest & cardiovascular; abdominal; hands, arms & lower limbs; reflexes; motor skills; back and spine; cranial nerves; male genitalia, prostate & rectal exams; female genitalia, gynecological & breast exams; mini-mental status exams; neurological exams and nutritional exams.

Minor Office Procedures: i.e. Wound dressing, ear cleansing, and wart treatment.

Medicinal use of Nutrition: i.e. Therapeutic nutrition, and nutritional supplements.

Physical Medicine: i.e. Therapeutic ultrasound and electrical muscle stimulation, manipulative therapy, muscle stretching/massage, constitutional hydrotherapy.

Botanical Medicine: i.e. Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.

Homeopathic Medicine: The use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing responses, i.e. homeoprophylaxis and biotherapeutic drainage.

Detoxification: i.e. Heavy metal and environmental detoxification.

Chinese Medicine: i.e. Acupuncture, electro-acupuncture, cupping, electrical stimulation, TDP lamp, MIT Therapy, Chinese herbal medicine.

Lifestyle Counseling and Hygiene: i.e. Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risk: Allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential Benefits: Restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease of its progression.

Notice to Women: All female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Integrative Medical Specialists or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand Integrative Medical Specialists will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative in writing, or unless it is required by law. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will not be kept more than ten years after the last day of my last treatment. I understand that any questions concerning this form can be asked of the doctor.

Name of Patient/Guardian _____ Date _____
Sign

Name of Patient/Guardian _____ Relationship _____
Print

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ELECTRONIC COMMUNICATION CONSENT

I, _____, am an established patient of Integrative Medical Specialists, LLC., (IMS) and I wish to participate in medical electronic mail (e-mail.) I understand that this e-mail will not be entirely secure/private, although IMS will take every precaution to protect my privacy. All patient e-mail correspondence will be through a separate encrypted e-mail system.

Electronic communication such as email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls, but there are important differences. E-mail is not the same as calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us, if you could identify the nature of your request in the subject line of your message. Please also confirm your name and Date of Birth. Below are our rules for contacting us using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include supplement refill requests, referral and appointment scheduling requests and billing/insurance questions.
- I also understand that if my messages require more than just a quick response from my doctor at IMS, I will either be billed for the doctor's time or may receive a reply that I need to schedule an appointment.
- I also understand that this mode of communication is to be used for non-urgent questions or communication only. Any urgent messages or needs will be relayed using regular telephone communications. IMS has informed me that it may take up to three (3) working days to receive a response to my e-mail query.
- E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail is not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment.
- E-mails may be forwarded to our staff for handling, if appropriate.
- Finally, either one of us can revoke permission to use e-mail electronic communications at any time, which will impact future and not past communications.

I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition, if I live outside of the state of Kansas in which my doctor is licensed. (Please initial consent option below.)

Email Communications:

_____Yes, I have read this consent to E-Mail communication and want to communicate with my doctor/staff electronically.

_____No, I do not consent to E-mail communication and do not want to communicate with my doctor/staff electronically.

Join Our Mailing List:

IMS offers electronic and print notifications including but not limited to health programs, event notifications, discounts, and newsletters. If you opt in you will receive an email that will require you to confirm that you wish to sign up.

_____ Yes (OPT IN), please notify me of health programs, event notifications, discounts, and newsletters using electronic and print notifications.

_____ No (OPT OUT), Please do not notify me of health programs, event notifications, discounts, and newsletters.

Please complete all information below:

_____ _____

E-mail Address State of Residence

I have fully read and understand the above consent and authorizations.

_____ _____

Print Patient Name Chart ID (Office Use Only)

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Printed Legally Authorized Individual Signature Date

The information contained in this e-mail is confidential, privileged, or otherwise protected from disclosure. It is intended only for the use of the authorized individual as indicated in the e-mail. Any unauthorized disclosure, copying, distribution or taking of any action based on the contents of this material is strictly prohibited. Review by any individual other than the intended recipient does not waive or give up the physician-patient privilege. If you have received this e-mail in error, please delete it immediately.

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NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT FORM

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Integrative Medical Specialists, LLC., (IMS) has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact IMS at 913-825-6111.

I also understand that I am entitled to receive updates upon request if IMS amends or changes its Notice of Privacy Practices in a material way.

Patient's Name _____ Patient's DOB _____

_____ _____
Patient Signature Date

_____ _____
Guardian or Legal Representative Signature Relationship

FOR OFFICE USE ONLY
I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because: [ ] Patient declined to sign this Written Acknowledgment. [ ] Other (specify): _____ _____ _____ Signature and Title Date
This section is to be completed by IMS if unable to obtain written acknowledgement from patient.

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TELEPHONE AND VOICEMAIL COMMUNICATION CONSENT

Integrative Medical Specialists, LLC., (IMS) offers patients the opportunity to communicate by telephone and voicemail. There are risks of transmitting information by telephone and voicemail. Voicemail and recorded calls can be circulated, forwarded and stored. Backup copies may exist even after the sender or recipient has deleted them. Employers may record phone conversations and access voicemail messages when using work phones for communication. Patient understands IMS will use reasonable means to protect the security and confidentiality but due to these risks, IMS cannot guarantee the security of the information transmitted.

Consent to use of telephone and voicemail communications includes agreement with the following conditions:

- All communication by telephone and voicemail will be made part of the patients record, therefore other individuals authorized to access the patient record, such as staff and billing personnel, will have access to those messages.
- IMS cannot guarantee that any voicemail will be listened to or responded to within any particular time frame, therefore the patient shall not use voicemail for emergencies or other time-sensitive matters.
- IMS may forward information to staff and others as necessary for diagnosis, treatment, reimbursement and other handling. IMS will not forward to third parties without prior consent, except as authorized by law.
- If the patient's message invites a response from the provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the message and when the recipient will respond.
- The patient is responsible for protecting his/her password to access voicemail. Provider is not liable for breaches of confidentiality caused by the patient or third party.
- The patient should not leave sensitive medical information on voicemail, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.

To communicate by telephone or voicemail the patient shall:

- Include the patient's name, date of birth and category of the communication in the telephone call or voicemail (e.g., supplement refill or billing question.)
- Limit or avoid use of his/her employer's phone.
- Withdraw consent only by written communication to provider.

The HIPAA Privacy Rule permits health care providers to communicate with patients by phone and does not prohibit covered entities from leaving messages for patients on their voicemail or with a person who answers the phone. However, to reasonably safeguard the individual's privacy, IMS limits the amount of information disclosed unless written authorization is obtained. Limited information such as information necessary to confirm an appointment such as patient's name, doctor's name and appointment date and time.

The HIPAA privacy rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside of the Notice of Privacy Practices without the authorization of the patient. Messages that contain PHI require the patient to sign an authorization form to receive messages by phone or voicemail. For example, messages that contain PHI would be test results, medication/supplement information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment or payment related.

You may elect to have your PHI provided to you by a message from IMS by signing this form on the reverse side. Once you have signed the form, future communication concerning your PHI may be provided to the designated person(s) or on voicemail at the numbers you have authorized.

Patient Name _____ Date of Birth _____ Date _____

Primary Number _____ Secondary Number _____

Contact #1 _____ Relationship _____ Phone _____

Contact #2 _____ Relationship _____ Phone _____

Contact #3 _____ Relationship _____ Phone _____

I understand my HIPAA rights and I request that this office leaves messages, including those containing PHI for me with either of the two individuals listed above or by voicemail at the numbers listed above. I understand that it is my responsibility to keep IMS informed of any changes to this information and a new consent form must be filled out to authorize changes. I understand the risks associated with communication by telephone and voicemail between IMS and myself. I understand I have the right to revoke this consent in writing or may opt out of voicemail communication at any time.

_____ I wish to OPT IN for communication of protected health information by voicemail.

_____ I wish to OPT OUT of communication of protected health information by voicemail.

I acknowledge that I have read and fully understand this consent form.

_____ _____

Patient Signature Date

_____ _____

Guardian or Legal Representative Signature Relationship

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TELEPHONE CONSULTATION CONSENT

Integrative Medical Specialists, LLC., (IMS) provides telephone consultations for established patients. Phone consultations are only available for patients who reside in the state of Kansas in which my doctor is licensed. This informed consent for telephone consultation is a contractual agreement between you and IMS. Phone consults lack the nuances and richness of the face-to-face consultation. The doctor is unable to see non-verbal cues or do a physical exam. You may be required to come in for an in office visit if the consulting doctor feels that the information obtained via phone is not sufficient.

A phone consultation is your opportunity to ask questions about your health condition and discuss treatment options. Phone consults are appropriate for discussing the following with your doctor:

- Results of your diagnostic test.
- Understanding what diagnostic tests might help provide insight into your condition.
- Evaluating the supplements you are talking and asking any questions about medications and side effects or interactions.
- Checking in after starting a new supplement or treatment plan
- Discussing factors that might be causing or contributing to your health problem(s)

The following are **NOT** appropriate for phone consultations:

- Annual physical exams
- Consults for conditions that may require an exam such as palpation of the abdomen, listening to the lungs, etc.
- Treatment for conditions that require the doctor to do a visual assessment such as a rash, or looking at a sore throat, etc.
- Treatment for a new condition or diagnosis in which your doctor has not already done an in office evaluation
- Establishing a new patient doctor relationship

You will receive a call from your doctor at the number you provided at the time of your scheduled visit. We do require at least a 24 hour notice for cancellation of phone appointments. We may send you some paperwork, which is to be completed and returned prior to your scheduled phone appointment. All the fees are due at the time of service and may be paid by debit or credit card over the phone. Phone consults are charged at the rate of $87.50 per 15 minutes. This includes the amount of time for the phone consult and for the doctor's time to write up a treatment plan.

I _____have read the above information and understand the above policies and limitations of phone consultations.

_____ _____
Patient Signature Date

_____ _____
Guardian or Legal Representative Signature Relationship

_____
State of Residence

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Medication Form

Name:____ Date Completed:______________________________
Address:______________________________ City:________________ State: ________ Zip: _______________
Phone Number:___________________________________ Birth Date:_________________________________
Emergency Contact/ Phone:____
E-Mail ____
(Notification of sales, specials, and new products and services will be sent by e-mail.)

Allergies and Drugs to Avoid/Adverse Reactions:
____
____

Please list any other special dietary information and foods or ingredients you avoid. (ex: vegan, no gluten, etc.)
____
____
____

Current Medications:

List all medications, supplements, hormones and over-the-counter products you are currently taking.
Include the brand/manufacturer's name for supplements, hormone creams and over-the-counter products.

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Name:____ Dosage:________________________
Reason for Taking:________________________________ Directions:________________________________
Date Started:________________________________ Date Discontinued:______________________________

Patient Name:____

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Name:____ Dosage:______________________
Reason for Taking:_____________________________ Directions:____________________________
Date Started:____________________________ Date Discontinued:____________________________

Immunization Record:
(Include dates administered)
☐ Tetanus_____________ ☐ Pneumonia Vaccine______________ ☐ Flu Vaccine____________________
☐ Hepatitis Vaccine_________________ ☐ Other____

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ADULT INTAKE FORM

Patient Name: _____ **DOB:** _____ **Age:**_____

List in Order of importance what your problems are:

1) _____
2) _____
3) _____
4) _____
5) _____

Last time you had blood work done and with what physician: _____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
Cancer type						
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please Note When & Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____
Ultrasounds: _____ Accidents: _____
TB Test: _____ HCV: _____
HIV: _____ Last Dental Visit: _____
Last Eye Exam: _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N
Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N
German Measles: D I N **Any vaccination reactions:** _____

Patient Name: _____ **DOB:** _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____

Soda Pop: Y N P **Ounces per day if Yes/Past**: _____

Alcohol: Y N P **How often & how much if Yes/Past**: _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

_____

_____

_____

Review of Systems

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____

Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle (**Y**) if you have the problem **NOW**, (**N**) if you've **NEVER** had the problem, (**P**) if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

Patient Name: _____ DOB: _____

EYES				
Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts/Glaucoma:	Y N P
Glasses:	Y N P		Styes:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark under Eyelid:	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		Cold sores:	Y N P
Sore Throat:	Y N P		Gum disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Loss of taste:	Y N P		Hoarseness:	Y N P
NECK				
Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P
RESPIRATORY				
Cough:	Y N P		TB:	Y N P
Shortness of breath w/ exertion:	Y N P		Bronchitis:	Y N P
Shortness of breath sitting:	Y N P		Pneumonia:	Y N P
Shortness of breath lying down:	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful breathing:	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pain:	Y N P
URINARY TRACT				
Incontinence:	Y N P		Pain w/ Urination	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Discharge/Blood:	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		Bowel Movement Freq:	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer	Y N P

Patient Name: _____ **DOB:** _____

MALE GENITALIA			
Testicular pain/swelling:	Y N P	**Sexually Active:**	Y N P
Hernia:	Y N P	**S.T.D.:**	Y N P
Discharge:	Y N P	**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P	**Sexual Orientation:**	Hetero Homo Bi

FEMALE GENITALIA			
Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Start date of last period:**	
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Scan:	Y N P	**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: _____

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

MENTAL/EMOTIONAL			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Patient Name: _____ **DOB:** _____

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long? _____ **Hobbies**: _____

Sleep

How long per night? _____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P **Hours worked per week**: _____ **Excessive exposure to environmental toxins:** Y N P

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom**: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Ethnic Background: _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, drugs, environment): _____