New Patient Intake Form

PATIENT INFORMATION

Name______________________________________Birthdate____________________M____F___
Address____________________________________City____________________State____Zip______
Social Security #____________________________
Primary Phone_________________________Secondary Phone______________________________
Employer_________________________________ Marital Status S____M____D/S____W_______
Emergency Contact_____________________________Phone_______________________________
Email Address____

INSURANCE INFORMATION

Insurance Company Name____
Name of Subscriber________________________Relationship to Patient_____________________
Subscriber Date of Birth____________________Subscriber SS#_____________________________
Group #__________________________________ID #______________________________________

Secondary Insurance? Yes______ No_______
Company Name____
Name of Subscriber________________________Relationship to Patient_____________________
Subscriber Date of Birth____________________Subscriber SS#_____________________________
Group #__________________________________ID #______________________________________

May we leave a voicemail regarding any test results or appointments? Yes______No_______

Do we have your permission to discuss your treatment with anyone other than yourself?
(Spouse/child/parent) Yes_______No___________
If so, please list____

Do you have a living will? Yes______No______If no, would you like a copy? Yes_____No______

Please list any allergies____
Pharmacy (and location)_____________________________________Phone_________________

Please list medications & supplements you are currently taking on the pink medication list

Past History

Surgeries: ____
Hospitalizations: ____
Major illnesses: ____
Major injuries: ____

Family History- *List all serious conditions e.g. age, at death, heart attacks, strokes, cancer (type), diabetes, other*

Mother: Currently Living? ___ Age____ Serious Illnesses: ______________________________
Father: Currently Living? ___ Age____ Serious Illnesses: ______________________________
Serious illnesses experienced by siblings: ____
Children and their age(s): 1. ___________________ 2. ___________________ 3. ___________________

Social History

Occupation: __________________________ Occupation hazard exposure: ________________________
What is your life vision, your passions? ____
Aerobic activity (e.g. walking) - type, daily or weekly amounts: __________________________________
Anaerobic exercise (e.g. weights) - type, daily or weekly amounts: ________________________________
Meditation/prayer - frequency and length: ____
Alcohol - type, daily & weekly quantities: ____
Cigarettes (packs per day): ____________
Caffeinated coffee (quantity): ___________
Caffeinated soft drinks (quantity): _________
Other soft drinks: _________
Illicit drugs (marijuana, others): _________

Eat organic? Y N
Vegetarian? Y N
Vegan? Y N
# of non-potato vegetables daily: ________
# of fruits daily: ________

Yes	No	Not Sure	**Spiritual History**:
			Have you had a near-death experience?
			Have you learned to do your best to make the world better and trust the outcome?
			Are you doing the work that you love and making the world better?
			Do you share your feelings?
			Can you find someone to call for a favor?
			Do you belong to a social group or are part of larger community? (i.e. sociable?)
			Do you have the ability to forgive yourself and others?
			Have you demonstrated the willingness to commit to a marriage or comparable long-term relationship?
			Do you experience intimacy, besides sex, in your committed relationships?
			Do you confide in or speak openly with one or more close friends?
			Do you or did you feel close to your parents?
			If you have experienced the loss of a loved one, have you fully grieved that loss?
			Has your experience of pain enabled you to grow spiritually?
			Have you connected with 'God'? – intuitions, premonitions, or other?
			Do you go out of your way or give your time to help others?
			Do you feel a sense of belonging to a group or community?
			Do you experience unconditional love?
			Have you eliminated judgment and criticism from your words and your life?

TURN OVER TO COMPLETE QUESTIONNAIRE

Checkmark next to those that apply:

___Sensitivity to light
___Brain fog (fuzzy headed)
___Impaired concentration
___Forgetful
___Anxious
___Sad
___Panic attacks
___Obsessive thoughts
___Shortness of breath
___Weight loss
___Persistent cough
___Bloody bowel movement
___Diarrhea
___Heartburn
___Joint pain
___Frequent urination
___Cold feet
___Change in moles
___Twitches
___Tick bite
___Nighttime leg cramps
___Put cell phone to ear
___Sleep near a wall/outlet
___Symptoms only at home, work, or school
___Tingling/odd sensations
___Headaches
___Dizziness
___Vision
___Taste disturbance
___Weight gain
___Heat intolerance
___Palpitations
___Wheezing
___Lethargy
___Bloating
___Black tarry bowel movement
___Abdominal cramps
___Abdominal pain
___Back pain
___Nighttime urination
___Calf pain w/ exercise
___Skin problem
___Tremors
___High blood sugar
___Restless legs in bed
___Daytime drowsiness
___Cordless telephones
___Perfume/odor sensitive
___Hearing loss
___Vertigo
___Dry eyes
___Smell disturbance
___Irritable
___Cold intolerance
___Chest pain
___Fatigue
___Sleep disturbance
___Sound sensitivity
___Constipation
___Hemorrhoids
___Nausea
___Swelling
___Blood in urine
___Near cell tower
___Muscles aches
___High cholesterol/triglyc
___Low hormones
___Bowel movement daily?
___Dream recall?
___Wireless internet
___Snore

In the last ten years have you had any of the following:

_____“Silver” mercury fillings
_____Eaten tuna fish weekly
_____Eaten fish 3 or more times a week
_____Eat packaged snack foods
_____Grew up in old house
_____Metal exposure work/hobby
_____Lived next to major highway
_____Cigarette smoke exposure
_____Exposed to car exhaust or gasoline fumes
_____Lived in a city where the air was polluted
_____Coal dust or mercury exposure
_____Grew up exposed to car exhaust or gasoline fumes
_____Year of last colonoscopy
_____Year of last bone density scan
_____Year of last complete physical exam
_____Year of last eye exam

Women:

_____menopausal?
_____last menstrual period
_____menstrual cramps
_____last pap smear
_____last mammogram or thermogram
_____heavy periods
_____low sexual interest
_____irregular periods
_____sore breasts
_____vaginal dryness
_____hot flashes
_____night sweats
_____premenstrual irritability, anxiety, sadness, swelling, migraine, or insomnia

Men:

_____low sexual interest
_____poor sex performance
_____loss of drive
_____nighttime anxiety
_____night sweats
_____loss of confidence
_____loss of strength
_____discharge from penis
_____curved penis
_____PSA level
_____date of last prostate blood test (PSA)

Main Concerns:

____

____

What is your goal for the first visit?

____

MIDWAY CENTER FOR INTEGRATIVE MEDICINE (MCIM)
129 SOUTH WINTER STREET
MIDWAY, KENTUCKY 40347
859-846-4445

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_______________________________________ ____________________

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that MCIM may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

MCIM has a detailed document called the ***Notice of Privacy Practices***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *Notice* before signing this agreement. If I ask, MCIM will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow MCIM to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that MCIM has taken action relying on this consent.

____ _______________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ _______________

Relationship to Patient (if signed by another party) **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *Notice*, at any time by contacting MCIM 129 South Winter Street Midway, KY 40347 859-846-4445.

INTEGRATIVE CARE CONSENT FORM

Midway Center for Integrative Medicine (MCIM) offers nutritional care support through nutritional information and nutritional products to support health. Nutrients that are utilized include vitamins, minerals, amino acids, and herbs. These nutrients are not specifically approved by the Food and Drug Administration for any medical condition. As with pharmaceutical treatments, there can be side effects to these approaches and interactions with medications that could be life threatening, cause morbidity, or lead to hospitalization.

By signing this form, I, the patient, acknowledge that these could occur and pledge to seek immediate care if there is concern (an example is bleeding). I, the undersigned, assume all responsibility for decisions I make regarding use of nutrients, recognizing that: A) no claims are made that dietary, nutritional, or herbal recommendations can treat or cure any medical condition, B) all recommendations are given for informational purposes only, C) there is no implied or stated guarantee of success or effectiveness of any specific dietary , nutritional, or herbal recommendation, and D) I am free to act upon or disregard the recommendations of James P. Roach, MD; Dee Dee Carman, APRN-C; Wendy Enneking, APRN-C; Marie Vaubourg-Manheim, APRN; and Lisa Carson, ND as I choose. I hereby release James P. Roach, MD,; Dee Cee Carman, APRN-C; Wendy Enneking, APRN-C; Marie Vaubourg-Manheim, APRN; and Lisa Carson, ND from all responsibility for my actions and any consequences thereof in the present time and in the future with no constrains. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of the MCIM team including any one of these practitioners to participate in a professional relationship with them pursuant to the statement herein.

Due to the potential for interaction with medicine, we recommend that you keep other healthcare providers informed of nutrients you take. We strive to make you aware of all options for your care including prescription treatments. If prescription medications are the approach you wish to take, please let us know and disregard nutrient recommendations.

Our office rarely uses scheduled prescription drugs; please seek another practitioner if you feel you require use of these medicines.

Dated this _______ day of ___________________________________, 201___.

______________________________________ ____________________________________

Patient Signature Printed Name

____

Witness Signature

New Patient Intake Form

Medication List

Patient Name: ____**DOB:** _________________

Date:					
Rx or Supplement:	**Dose:**	**Dose:**	**Dose:**	**Dose:**	**Dose:**