ADVANCED INTEGRATIVE WELLNESS

New Patient Registration

First name:_____ Last Name:_____

MI:_____ Date of Birth:___/___/_____ Age:____ Gender:_____

Sex at Birth: M / F circle one

Email Address:_____

Street Address:_____

City:_____ State:_____Zip:_____

Primary Phone Number:(_____)_____-_____ Cell /Home/ Work circle one

May we leave a message at this number with personal health information? Y / N

Secondary Phone Number:(____)_____-_____ Cell /Home/ Work circle one

May we leave a message at this number with personal health information? Y / N

Emergency Contact Name:_____

Emergency Contact Phone Number:(____)____-_____

Relationship of Contact to Patient:_____

Preferred Pharmacy:_____

(name, street address, zip code)

Pharmacy Phone Number:(____)____-_____

Primary Care Physician Name:_____

Address:_____

Phone:(____)____-_____

I hereby certify, the above is current and correct information pertaining to myself or as a parent or guardian

Printed name of parent or guardian if applicable:_____

Signature:_____ Date:___/___/_____

Personal Health History & Self Reflection Inventory

Primary Reason for Your Consultation:_____

What Are Your Health and Wellness Goals?:_____

Past Medical History: List Any **Major** Illnesses, surgeries, hospitalizations, (include year or date if known)

Condition/Surgery/Hospitalization	Date:	Condition/Surgery/Hospitalization	Date:
1.		4.	
2.		5.	
3.		6.	

Please list all prescribed and over the counter medications you take regularly. **Please include all supplements, vitamins, or herbal products:**

Medicine/supplement including dose	**Frequency**
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Do you have any medication allergies? YES / NO Please circle one **If yes, please list**:

Medication and Reaction	**Medication and Reaction**

Do you have food or environmental allergies? YES / NO Please circle one **If yes, please list:**

Food/other and reaction	Food/other and reaction

Please outline your use of the following, past or present:

Product	Current Use? Yes No	Quantity Per Day	Quantity Per Week	Past Use? Yes No	Do others have concerns about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine					

Please list all dietary restrictions (vegetarian, gluten free, etc.): _____

Average hours of sleep per night:_____ **Do you have sleep difficulties: Y / N** Circle all that apply

Difficulty falling asleep / Staying asleep / Waking in the night / Daytime sleepiness / Snoring / Sleep Apnea / Sleeping too much / Other:_____

<u>Family History</u>: Have your close relatives (parents, siblings, children, grandparents) had any of the following?

	Yes	If yes, who and what age at diagnosis
Kidney Disease		
Osteoporosis		
Rheumatoid Arthritis		
Asthma		
Heart Attack		
Stroke		
High Blood Pressure		
High Cholesterol		
Diabetes		

Thyroid Disease		
Breast Cancer		
Other Cancer, and what type		
Mental Health Disorder		
Substance Abuse		

Preventative Health: **Please provide the dates and documentation when possible**

	Date		Date
Pap/Pelvic Exam (F)		**Tetanus (specify Td or Tdap)**	
Mammogram (F)		**Flu vaccine**	
Colonoscopy		**Pneumonia Vaccine**	
Test of stool for blood (Stool Guiac)		**Zoster (Shingles) Vaccine**	
Rectal Prostate Exam (M)		**Hepatitis A Vaccine**	
Prostate Specific Antigen (M)		**Hepatitis B Vaccine**	
Bone Density		**MMR Vaccine**	
Eye Exam		**Gardasil (HPV Vaccine)**	
Cardiovascular Stress Test		**Covid 19 Vaccine (how many)**	

Review of Symptoms: Please check yes or no for the following **Current** symptoms within the last 3 months

General	Yes	No	**Gastrointestinal**	Yes	No
Fever			Diarrhea/Constipation		
Hot Flashes			Indigestion/HeartBurn		
Sweats at Night			Nausea		
Temperature Intolerance			Blood in Stool		
Excessive Thirst			**Genitourinary**		
Fatigue			Pain or Burning in Urination		
Sleep Difficulties			Frequent Urination		
Daytime Sleepiness			Waking To Urinate More Than Once at Night		
Unplanned Weight Change			Excessive Urination		
Skin			Difficulty Emptying Bladder		
Rash			Urinary Incontinence		
New or CHanging Moles			Decreased Sexual Desire		
Eyes			Pain With Intercourse		
Pain			Sexually Transmitted Disease		
Redness			Fertility Issue		
Vision Change			**Men:**		
Ear, Nose, Throat			Erectile Dysfunction		
Hearing Loss			**Women:**		
Ringing in Ears			Heavy Vaginal Discharge		
Dizziness or Vertigo			Heavy Menstrual Bleeding		
Bleeding Gums			Painful Menstrual Periods		
Nosebleeds			Irregular Menstrual Bleeding		
Breast			**Musculoskeletal**		
Breast Pain			Generalized or All-Over Pain		

Masses of Lumps			Joint Pain		
Nipple Discharge			Stiffness		
Skin Changes			Joint Swelling		
Cardiovascular			Joint Redness		
Chest Pain			Back or Neck Pain		
Heart Murmur			**Neurological**		
Irregular Heart Beat (palpitations)			Abnormal Gait (Trouble Walking) or Falls		
Leg Swelling or Edema			Headache Severe and/or Frequent		
Pulmonary			Seizures		
Wheezing or Shortness of Breath			Muscle Weakness, TIA or Stroke		
Chronic Cough			Fainting or Loss of Consciousness		
Hematopoietic			Localized Numbness, Tingling, Neuropathy		
Swollen Lymph Glands			**Psychological**		
Blood Clots			Anxiety		
Excessive Bleeding			Depression And/or Mood Swings		
Anemia			Memory Loss		

(Women Only) Past GYN/Obstetrical History: List any past Pregnancies

Vaginal Births		Miscarriage/Still Births	
Caesarian Section		Pregnancy Terminations	
Abnormal PAP Tests		Other GYN Procedures	

MALE Hormone Health Assessment:

Symptom Check List	Never	Mild	Moderate	Severe
Decline in General Wellbeing				
Fatigue				
Joint Pain and Muscle Aches				
Excessive Sweating				
Sleep Problems				
Increased Need For Sleep				
Irritability				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion/Lacking Vitality				
Declining Mental Ability/Focus/Concentration				
Feeling You Have Passed Your Peak				
Feeling Burned Out/Feeling You've Hit Rock Bottom				
Decreased Muscle Strength				
Weight Gain/ Belly Fat/ Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease In Beard Growth				
New Migraine Headaches				
Decreased Desire Libido				
Decreased Morning Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejeculations				
No Results from E.D Medications				

Family History	Yes	No

Alzheimer's Disease		
Heart Disease		

FEMALE Hormone Health Assessment:

Symptom Check List	Never	Mild	Moderate	Severe
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Desire/Libido				
Sleep Problems				
Mood Changes/Irritability				
Migraines/Severe Headaches				
Difficulty to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold All the Time				
Swelling All Over Body				
Joint Pain				

Family History	Yes	No
Alheimer's Disease		
Breast Cancer		
Heart Disease		

PRIVACY POLICY AND CONSENT FORM

Overview of pertinent policies for Advanced Integrative Wellness:

1. Patient information will be confidential as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as personnel desks and exam rooms. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the work environment for handling charts, patient records, PHI, and other documents or information.
2. At times we may need to contact you regarding appointment scheduling and other communications informing you of practice policy changes and new technology/treatments available that you might find valuable or interesting. We may do this by telephone, text, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you.
3. The practice utilizes vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by privacy practices.
4. You agree to bring any concerns or complaints regarding privacy to your Provider or Office Manager.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
6. We agree to provide patients with access to their health records in accordance with the state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and practice.

I do hereby consent and acknowledge my agreement to the terms set forth and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forth.

Print Name_____ **Signature** _____

Today's Date_____

Authorization for Treatment

Advanced Integrative Wellness

Please initial after each statement and sign at the bottom.

Authorization for Treatment

I authorize examination, diagnosis and general treatment (including but not limited to the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by the providers at Advanced Integrative Wellness. If necessary, I give my permission for other allied health professionals to review my medical record for the purpose of the evaluation of my overall health needs. I realize that if a medical procedure or surgery is required, I will be given additional information.

Initial Here_____

Release of Information

I hereby authorize Advanced Integrative Wellness to furnish information from my medical record to any health care provider necessary to provide for the continuity of my medical care with the exclusion of information regarding substance abuse, mental health, HIV (AIDS), STD, etc.

Initial Here_____

No Show/Missed Appointments

Patients must show up on time for their appointment. If you are late, we will reschedule your appointment in order to keep the schedule on time for the following patients. You will still be charged for this missed appointment time. Multiple late occurrences may result in discharge from our practice.

I understand that appointments that are not rescheduled or canceled at least 24hrs before the scheduled appointment time, are liable for a late fee. I understand that if I cancel reschedule an appointment the day of, the full appointment fee will be charged to my card.

Initial Here _____

Financial Agreement

*****Payment for Office Visits are Due at the time of Your Appointment*****

I agree that my card will be kept on file and all appointment services will be charged to that card at the time of service, unless I request another form of payment to be processed. For all other service fees: when collection efforts indicate that a patient/guarantor is unable to pay for services we will try to negotiate a payment arrangement. In the event that no attempt is made to set up a payment plan or the terms of the payment plan are not complied with, the account balance will likely be sent to a collection agency. I assign and authorize payments to be made directly to Advanced Integrative Wellness.

Initial Here_____

Printed Name:_____

Signature (Parent or guardian may sign for minors):_____

Date:_____

Authorization for Use or Disclosure of Protected Health Information

Please list all family members or other persons, if any, whom we may discuss your medical condition and diagnoses with. You may leave this blank if you do not authorize us to disclose information with any other person.

NAME:_____Relationship _____

NAME: _____Relationship_____

NAME:_____Relationship_____

I understand that I have a right to:

- Inspect or copy the protected health information to be used as permitted under federal law.
- Refuse to sign the authorization.
- Terminate this agreement at any time upon receipt of a signed written request.
- I hereby authorize the use or disclosure of my health information as described below. I understand this authorization is voluntary; I understand that the related information may not be protected by federal privacy regulations.

Patient Printed Name_____ Date of Birth_____Date_____