12450 Roosevelt Blvd N, Ste101, St Petersburg, FL 33716
Ph# 727-571-1688 Fax# 727-561-0674
colinchanmd.com

Email completed paperwork to office@drcolinchanmd.com
one week prior to appointment.

Permission To Share My Medical Records & Consents.

Patient Name:_______________________________________Date of Birth:________________________

1.Physician Name:	**2 Physician Name:**
Specialty:	**Specialty:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone: **Fax:**	**Phone:** **Fax:**
3.Physician Name:	**4. Physician Name:**
Specialty:	**Specialty:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone: **Fax:**	**Phone:** **Fax:**

Please specify any limitations on the sharing of your medical records (ex. HIV, Substance abuse, "nervous breakdown", etc.)

PLEASE DO NOT SEND INFORMATION RE:____
{leave blank if no restrictions)

Permission to Treat: I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Colin Chan, M.D. and the healthcare providers of the West Coast Primary Care. deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Authorization: I hereby authorize the office of Colin Chan, M.D. and the Healthcare providers at the WCPC **to furnish and to receive my complete medical record** from the physicians listed above. For any limitations on the medical record request I notify Colin Chan MD/WCPC as indicated above. I hereby authorize the office of Colin Chan, M.D. and the Healthcare providers at the WCPC to furnish my medical information to my insurance carriers, and hereby irrevocably assign to these healthcare providers all insurance payments for medical services rendered by this office. I have received a copy of the WCPC /Colin Chan MD Notice of Privacy Policy. I understand that I am financially responsible for all charges whether or not covered by insurance. I understand that copay's/ payment for office visits is required at the time service is rendered.

Valuables/ Limitation of Liability: I understand that I should not bring valuables Jewelry, irreplaceable documents, etc.) with me to WCPC. I agree that WCPC shall not be responsible for valuables. WCPC is not responsible for them, even if I give them to other WCPC personnel. Unclaimed items in the WCPC Lost and Found are given to charity after 30 days.

______________ ____X._____________________________

Date Patient Signature Guardian Signature

COLIN CHAN, M.D. & ASSOCIATES

Patient Name: ___________________________________ DOB: ____________

Acknowledgement of Receipt of "Notice of Privacy Practices" & Permission to Share Protected Health Information

You May Refuse to Sign This Acknowledgement

Our "Notice of Privacy Practices" provides information about how we may use and disclose "Protected Health Information" or "PHI" about you. You have the right to review our Notice before signing. The terms of our notice may change. If we change our notice, you may obtain a revised copy.

By signing this form, you consent to our use and disclosure of protected health information. You have the right to revoke the consent, in writing, and signed by you. However, such a revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

E-mail address for use with **Patient Portal:** ___________________________________

Preferred Phone number to call for appointment reminders: ___________________________________

Pease share **non-work email** with us for use with our patient portal. The portal will enable you to communicate with us securely via the internet. You will be able to retrieve portions of your test results and medical record via the portal. We will send you appointment reminders for upcoming visits to Colin Chan, M.D. via this email address and via phone messaging.

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

Name:_________________________ Relationship______________________ Ph#______________________

Name:_________________________ Relationship______________________ Ph#______________________

Name:_________________________ Relationship______________________ Ph#______________________

May we leave or send a message regarding your health or upcoming appointment via email and/or on your answering machine and/or on your cell phone and/or your work number?

_________ **Email** (YES/ NO)   _________Home Answering Machine (YES/ NO)   _________Mobile phone **(YES/ NO)**

May we call you at work and leave you a message to call our office? _________ **Work** phone **(YES/ NO)**

- You may revoke this consent at any time in writing.
- You may refuse to sign this acknowledgement and authorization, in doing so we will not be allowed to process your insurance claims.

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign   _______ An emergency situation

_______Communication barriers   _______ Other (PleaseSpecify)

Date: __________   Signature: ____

Practice Terms of Acknowledgement

Colin Chan MD & Associates strives to give the best care and information to our patients. We are your partners in health. To be transparent regarding our office policies for appointments, prescription refills and services please read carefully.

- Wellness program- This is optional plan for patients who want more one-on-one care with the physician. The plan consists of expedited appointments, four home visits a year, discounts on supplements and procedures, 24/7 access to the physician via cell phone or text, specialty labs and longer appointments. The fees and tiers are in our handout. If you choose not to join the program you will see Dr Chan for three visits and then our experienced nurse practitioner Karen Johnson APRN will take over your care.
- Refills-If you are taking a prescription that requires an appointment every thirty days, make sure to make your follow up appointment prior to the refill date or at time of check out to ensure you do not run out of your medication. Our schedule fills up quickly and you might not get in before the refill is due.
- Random drug testing will be performed if you are taking any drug that is classified a control substance and will be billed to Precision Diagnostics/Quest/Labcorp for analysis.
- New prescriptions including antibiotics, change of medications or referrals requires a follow up appointment due to documentation.

Refill protocols below

- Controlled Pain/Weight Medications-Appointment every 30 days.
- ADHD/Anxiety Medications-Appointment every 1-3 months.
- Hormones/Testosterone/Sleep Medication-Every 3 months.
- Suboxone-Every 1-4 weeks.
- Blood pressure/ Diabetic Medications-Every 3-6 months.

I have read and acknowledged the above terms.

______________________________ ________________

Patient Signature Date

12450 Roosevelt Blvd N, Suite 101, St Petersburg, FL 33716
727-571-1688 Fax# 727-561-0674

Colin Chan, M.D./West Coast Primary Care Financial Policy

Colin Chan, M.D., is committed to excellence in patient care and providing you with the best patient care experience possible. In order to make sure that your experience at Colin Chan MD/WCPC is as smooth as possible, please familiarize yourself with our financial policy. Below is a summary of important points Please read and sign in the spaces provided below.

- A patient's health insurance policy is a contract between the patient and their health insurance company. It is the patient's responsibility to check what is covered under their policy.
- At WCPC/Colin Chan MD, all co-pays and deductibles are due at the time of treatment.
- Outstanding balances older than 90 days, that are determined to be the patient's responsibility will be sent to a collection agency.
- For out of network insurance plans - patients (or their guarantors) are responsible for payment of their office visit in full.

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- For self-pay patients - payment is expected at the time of service unless other financial arrangements have been made prior to the patient's visit.
- The fee for a bounced check is $25.00 - $40.00 or 5% whichever amount is greater, and the patient will lose the privilege to write checks in our office.
- We ask that the patient call to cancel their appointment at least **48 hours** in advance. If insufficient notice prior to cancellations given, patients may be responsible for cancellation fees as outlined below, unless waived by a physician:
- **Cancellations/Reschedules $20.00 fee.**
- **No Show appointments $25.00.**
- Medical records copies: There is no charge for one set of medical records. Additional records requests will be charged
- **Assignment of insurance benefits**-In consideration of all health care services rendered to me or the patient named below by WCPC/Colin Chan MD. I hereby assign benefits to WCPC/Colin Chan MD all rights, title and interest in any third-party benefits due from any and all insurance policies and/or responsible third-party payers in an amount not to exceed WCPC/Colin Chan MD for regular and customary charges for the health care services rendered. I authorize such benefits to be paid directly to WCPC/Coin Chan MD. I agree to cooperate with WCPC/Colin Chan MD and or its agents in their efforts to secure payments from my insurance carriers, third party payers, and or other third-party payers. I consent to any request to review or appeal by WCPC/Colin Chan MD to challenge a determination of benefits made by a third party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided to me are covered by my insurance or other third-party payer.

I acknowledge receipt of Colin Chan, M.D./WCPC financial policy and that a copy of this summary shall remain in my chart. By signing below, I have read & understand any financial responsibilities described above in this *Financial Policy Summary.* Also, I authorize healthcare providers at Colin Chan, M.D.& WCPC to release any information regarding my treatment for insurance purposes. I also authorize to release my information to other physicians or institutions as necessary for my treatment. I understand that any information given regarding my treatment shall remain CONFIDENTIAL and will be released only as necessary as it relates to my care or treatment.

By signing below, I am indicating that I have reviewed and consent to the terms described above:

Date: ________ Patient Name:____________________ Signature:____________________________________

COLIN CHAN, M.D. & ASSOCIATES

PATIENT NAME_________________________________DOB ______________

BEHAVIOR CONTRACT

As a patient in this office, you have a responsibility for conducting yourself in a manner consistent with appropriate behavior. We are establishing expectations as to what is, and is not, considered "appropriate behavior" with respect to what will be tolerated in our office. "Appropriate behavior" is defined, but not specifically limited to, the following:

1. You will neither threaten nor carry out any form of physical abuse to any physician or other staff members involved in your care in this office.
2. You will not touch any physician or other staff members involved in your care.
3. You will not emotionally, psychologically or mentally abuse any physician or other staff member involved in your care. Examples of such activities include, but are not limited to, swearing, bullying, insulting, demeaning, degrading or otherwise using offensive language during the course of office visits, telephone calls, e-mails or other communication with the office staff during the course of your seeking care. Such behavior will not be tolerated at any time and may result in your being transferred from the office's care.
4. You will also conduct yourself appropriately with other patients seeking care in the office. Failure to do so will be considered the equivalent of acting with inappropriate behavior to the staff.
5. You will come to your appointments as scheduled. You will not consistently cancel or "No-show" for appointments. You will have ample opportunity to change appointments when absolutely necessary, but no-call, no-show will not be tolerated. Processes are in place to transfer you from the practice if necessary.

Our Commitment & Responsibilities to You

We are committed to doing all we can to treat your health conditions. We consider our working with you to be a partnership where we will work together cordially and respectfully to help you achieve your best health. As a part of that commitment, we will offer you recommendations as to treatments and/or therapies to help you achieve your best health. Moreover, we will respect your choices and decisions with respect to how you wish to manage and address your health.

Patient Statements

I have been informed that in order to remain a patient of the practice, I need to conduct myself so that my behavior is appropriate within the office setting. Appropriate behavior needs to be exhibited to any physician who practices in the office as well as to the office staff. Appropriate behavior also needs to be exhibited towards other patients on the premises who are seeking care for their own maladies.

I have been informed and understand that, while my physician will make recommendations as to treatments and/or therapies that could improve my health, my physicians will ultimately respect my decisions with regard to management of my health and well-being.

In addition, I authorize West Coast Primary Care to provide a copy of this agreement to my pharmacy, other healthcare providers, or insurance carrier upon request. I also authorize and consent to allow my physician/APRN and any other office personnel to disclose or share my medical information and treatment received with any other third parties for purposes of treatment and/or payment purposes. In addition, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to authorizing West Coast Primary Care and its personnel to cooperate fully with any state or federal law or any state or federal agency (eg. CMS).

I certify that the information provided by me is correct to the best of my knowledge. West Coast Primary Care or any staff members will not be responsible for any errors or omissions that occur secondary to incorrect or incomplete data on this form.

By signing I affirm that I have read, understand, and agree to all of the above authorizations and policies

Signature ____ ______/_______/_________

Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) ___________________________

Notice of Privacy Practices

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Colin Chan, M.D. (WCPC) is dedicated to maintaining the privacy of your health information. This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Notice of Privacy Practices describes how WCPC may use and disclose your protected health information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. It also describes your right to access and control your PHI. Your "PHI" means any written or oral information about you including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health condition.

Use and Disclosure of Health Information

Colin Chan, M.D./WCPC may use your PHI for the purposes of providing treatment, obtaining payment for treatment and conduction of health care operations. Your PHI may be used or disclosed only for these purposes unless we have obtained your authorization, or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your PHI for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. Treatment.

We **will** use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your PHI for treatment:

A. We may disclose your PHI to a laboratory or diagnostic center to ordertests.
B. We may disclose your PHI to other physicians who may be treating you or who are consulting with us regarding your care.
C. We may disclose your PHI to those who may be involved in your care after you leave here, such as family members or your personal representative.

2. Payment.

We will use your PHI to obtain payment for the services we provide to you. We may also disclose your PHI to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your PHI for payment: We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.

3. Health Care Operations.

We may use and disclose your PHI to facilitate our own health care operations and to provide quality care to all our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your PHI to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your PHI for health care operations:

A. We may use your PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.
B. We may combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
C. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

D. We may also use or disclose your PHI in the course of maintenance and management of our electronic health information systems.

4. Other Uses and Disclosures.

As part of the functions above, we may use or disclose your PHI to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

Uses and Disclosures of PHI Permitted Without Authorization or Opportunity for the Individual to Object

The Federal privacy rules allow us to use or disclose your PHI without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. When Required By Law. We will disclose your PHI when we are required to do so by federal, state, or local law.

2. For Public Health Reasons. We may disclose your PHI as permitted or required by law for the following public health reasons:

a. For the prevention, control, or reporting of disease, injury or disability;
b. For the reporting of vital events such as birth or death;
c. For public health surveillance, investigations, or interventions;
d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including;
e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
f. Under certain limited circumstances, to report to employer information about an individual who is a member of the employer's workforce.

3. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agreesto the disclosure.

4. For Health Oversight Activities. We may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

5. For Judicial or Administrative Proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your PHI in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court of administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.

6. For Law Enforcement Purposes. We may disclose your PHI to a law enforcement official for law enforcement purposes, including:

a. Wound or physical injury reporting, as required by law.
b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
c. Identification or location of a suspect, fugitive, material witness, or missing person.
d. Under certain limited circumstances when you are the victim of a crime.
e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
f. Reporting criminal conduct that occurred on the premises of the provider.
g. In an emergency to report acrime.

7. To **Avert a Serious Threat to Health or Safety.** We may, consistent with applicable law and standards of ethical conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.

8. For Specialized Government Functions. We may use or disclose your PHI, as authorized or required by law, to facilitate specified government functions related to military and veterans' activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.

9. For Workers' Compensation. We may use and disclose your protected heath information, as necessary, to comply with workers' compensation laws or similar programs.

Uses & Disclosures of PHI Permitted without Authorization Required but with an Opportunity for the Individual to Object

We may disclose your PHI to a friend or family member who is involved in your medical care or payment for care. You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your PHI.

Uses and Disclosures of PHI which You Authorize

Other than the uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Authorizations are for specific uses of your PHI, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI:

1. The Right to Request Restriction of Uses and Disclosures. You have the right to request that we not use or disclose certain parts of your PHI for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your PHI to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies. We are not required to agree to a restriction you may request. We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your PHI in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment. We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to PHI created or received by us after you receive the notice of termination of the restriction. Request for restrictions must be made in writing to the Privacy Officer.

2. The Right to Request Confidential Communications. You have the right to request that you receive communications of PHI from us by alternative means or at alternative locations. We must accommodate reasonable request of this nature. Requests for confidential communications must be made in writing to the Privacy Officer.

3. The Right to Inspect and Copy PHI. You have the right to inspect and obtain a copy of your PHI that is maintained in a designated record set for as long as we maintain the PHI. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you. By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and PHI

which is subject to a law which prohibits access to PHI. We may deny your request to inspect or copy your PHI if, in our professional judgment, we determine that the access requested is likely to endanger you or another person. You have a right to request a review of a denial of access. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.
Requests for access to your PHI must be made in writing to the Privacy Officer.

4. The Right to Amend PHI. You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases, we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so we will provide a copy of our rebuttal to you. Requests for amendment of PHI must made in writing to the Privacy Officer and must include a reason to support the requested amendments.

5. The Right to Receive an Accounting of Disclosures of PHI. You have the right to request an accounting of disclosures of your PHI made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; or for certain other disclosures we are permitted to make without your authorization. Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14,2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.

6. The Right to Obtain a Paper Copy of this Notice. Upon request, we will provide a paper copy of this notice. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all PHI that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

7. You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer. You will not be penalized for filing a complaint.

Contact Information
For further information about this Notice or if you have privacy issues, or if you believe that your privacy rights have been violated, please contact our Privacy Officer @ 727-571-1688

COLIN CHAN, M.D. & ASSOCIATES

Please be certain that all intake forms are completed and returned to Colin Chan, M.D. at least 1 week prior to your appointmentdate. This information will be scanned into the electronic medical record.

Personal Health History & Self Reflection Inventory

Name:__________________________________ **Date:** __________________

Date of Birth____________ **Age** ______

What is the best contact phone #__________________________May we leave a message at this number? Yes No

What is your email____________________________________ May we leave you a message at this email? Yes No

Preferred Pharmacy (Name, location, phone #):____

Please list all physicians that you see. (Please include Mental Health Professionals)

Name	City, State	Specialty, or condition that is being treated

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Facility	Type of Treatment	Reason for Treatment	Beneficial Experience?

What health issues do you want to focus on during this visit?

Current Medical Problems **(e.g. diabetes, heart disease, hypertension, etc.):**

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical History: List any past illnesses, hospitalizations.

	Date		Date

Past Surgical History:

	Date		Date

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still births	
Caesarian Sections		Pregnancy Terminations	
Abnormal PAP tests		Other GYN Procedures	

Family History: Have your close relative(s) (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart Disease				
Stroke				
Dementia				
Cancer_______________				
Cancer_______________				
High Blood Pressure				
Diabetes				
Kidney Disease				
Lung Disease				
Thyroid Disease				
Autoimmune Disease				
Arthritis				
Mental Health Disorder				
Substance Abuse				

Pharmaceuticals and Supplements:

Do you have Medication allergies? ☐ Yes ☐ No If yes, please list:

Medication	Reaction	Medication	Reaction

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	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

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 concern about your usage?
Alcohol					
Tobacco					
Recreational Drugs					

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? ❑ Yes ❑ No

	Date		Date
Pap/pelvic exam (females)		Flu vaccine	
Mammogram (females)		Tetanus vaccine (specify Td or Tdap)	
Colonoscopy		Pneumonia vaccine (Prevar-13)	
Rectal prostate exam (males)		Pneumonia (Pneumovax)	
Prostate Specific Antigen (males)		Shingles (Shingrix/Zostavax)	
Eye exam		HPV (Gardasil/Cervarix)	
Bone Density (Dexa)		Hepatitis A/B	
Other:		Other:	

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		GASTROINTESTINAL	Yes	No
Low energy				Diarrhea		
Memory decline				Constipation		
Mod-severe stress				Nausea		
Mood swings				Blood in stool		
Sleep difficulties				Indigestion/heartburn		
Daytime sleepiness				**GENITOURINARY**		
Sleep apnea				Frequent urination		
Unplanned weight change				Waking to urinate more than once at night		
Skin				Difficulty emptying bladder		
Itching				Urinary incontinence		
Rash				Decreased sexual desire		
New or changing moles				Pain with intercourse		
EYES				Sexually Transmitted Diseases		
Vision Change				Fertility issues		
Redness				Pain or burning on urination		
Pain				**Men:**		
EAR, NOSE, THROAT				Loss of libido		
Hearing loss				Loss of sensation		
Ringing in ears				Erectile dysfunction		
Dizziness or vertigo				**Women:**		
Bleeding gums				Loss of sensation		
Nosebleeds				Abnormal vaginal discharge		
BREAST				Heavy menstrual bleeding		
Breast Pain				Loss of libido		
Masses and or Lumps				Painful Menstrual periods		
Nipple discharge				Irregular spotting/bleeding		
Skin changes				**MUSCULOSKELETAL**		
CARDIOVASCULAR				Generalized or all-over pain		
Chest pain/Pressure				Joint pain or stiffness		
Heart murmur				Joint swelling		
Irregular heartbeat (palpitations)				Joint redness or warmth		
Leg swelling or edema				**NEUROLOGICAL**		
PULMONARY				Headache severe or frequent		
Wheezing				Weakness of legs or arms		
Chronic cough				Trouble walking or falls		
Shortness of breath				Dizziness or lightheadedness		
HEMATOPOIETIC				Numbness, tingling		
Swollen lymph glands				TIA/Stroke		
Blood clots				**PSYCHOLOGICAL**		
Excessive bleeding				Anxiety		
Anemia				Depression		

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ☐ Yes ☐ No
If yes, is this an active issue in your life that you would like to address while you are here? ☐ Yes ☐ No

____

____

Movement, Exercise and Rest:
What forms of exercise and movement do you enjoy?
____
Please describe your usual physical activity

Activity	How often	How long each time

How many hours of sleep do you usually get each night? ____
Describe any issues you have with sleep.____
____

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours.

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No If yes, please describe:____
Are you comfortable with your relationship with food? ❑ Yes ❑ No
Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No
Who prepares your meals? ____

Personal and Professional Development:
Current or past occupation: ____
❑ Retired? ❑ Working at home? ❑ Caretaking? ❑ Disabled? ❑Unemployed?

Are you happy with your occupation? _ ☐ Yes ☐ No
Why? ____
____
Do you anticipate any work changes in the near future? Retirement, etc. ______________________________
____
What racial/cultural heritage(s) do you identify with? ____
____

Relationships:
Relationship status: ___________ if married or partnered, what is your relationship length? ____________
What are your living arrangements?______________Number of children and ages: ___________________
Are you sexually active? ❑ Yes ❑ No Are you happy with your sexual life? ________________________
If no, describe reasons/symptoms:____
Which relationship(s) fulfill and/or empower you? ____

Who or what drains your energy? ____

Physical Environment:

Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?

____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

____

Spirituality:

What things or activities bring you your greatest joy and meaning? What inspires you?

____

____

What things create the greatest challenges for you? ____

____

What makes you feel connected to the larger world? -Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance, etc.).____

____

If time and money were not an issue, describe the things you long to do in your life.______________________

____

____

Mind-Body Connection:

Rate the amount of stress in your life: □ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme

How well do you manage stress? □ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.) ______________________

____

What are your methods of coping with the stress in your life? ______________________________________

____

What are your health goals? What are your overall goals for improving your health and your life? ____

____

____

____

____

Is there anything else that would be helpful for us to know about you? ________________________________

____

____