ADULT HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

PREFERRED PHARMACY & LOCATION: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/supplements/remedies and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox__	Date:_____	Meningococcus__	Date:_____
Flu Shot__	Date:_____	MMR *(Measles, Mumps, Rubella)* __	Date:_____
Gardasil/HPV__	Date:_____	Pneumonia__	Date:_____
Hepatitis A__	Date:_____	Tdap *(Tetanus and pertussis)*__	Date:_____
Hepatitis B__	Date:_____	Tetanus__	Date:_____
		Zostavax *(Shingles)*__	Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal

Last Mammogram Date _____ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

Cesarean sections If yes, then number: _____

Bleeding between periods__

Heavy periods__

Extreme menstrual pain__

Vaginal itching, burning, or discharge__

Wake in the night to go to the bathroom__

Hot flashes__

Breast lump or nipple discharge__

Painful intercourse__

Sexually active__

INTEGRATIVE FAMILY CARE PLLC

PATIENT NAME_____

Current sexual partner is Female Male
Do you use condoms Yes No
Other Birth control method used:_____

PAST MEDICAL HISTORY

Please circle all that apply:

Anxiety Disorder or Depression
Arthritis
Asthma
Bleeding Disorder
Blood Clots (DVT), Pulmonary Embolism (PE)
Cancer
Coronary Artery Disease
Autoimmunity
Diabetes - Insulin
Diabetes - Non-Insulin
Dialysis
Diverticulitis
Fibromyalgia
Gout
Has Pacemaker
Heart Attack
Heart Murmur
Hiatal Hernia or Reflux Disease
HIV or AIDS
High Cholesterol
High Blood Pressure
Thyroid Disease
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Eczema
Food Intolerance
Stroke
Tuberculosis
Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
1.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Grandfather (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Other:_____	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease or Autoimmune Disorder Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade
High school

Caffeine None Occasional
Moderate Heavy

If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks./day

INTEGRATIVE FAMILY CARE PLLC

PATIENT NAME_____

2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level
None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week?
# of cups/cans per day? ____

Tobacco Do you use tobacco?
Yes No
Chew - ____/day
Cigars - ____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please circle all that apply:

Allergic/Immunologic
- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular
- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional
- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____lbs)
- Weight Loss (____lbs)

Eyes
- Dry Eyes
- Irritation
- Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine
- Fatigue
- Increased
- Thirst/Hunger/Urination

Gastrointestinal
- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary
- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic
- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)
- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal
- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological
- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric
- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory
- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

_____
Parent, Guardian, or Caregiver Signature

_____
Date

INTEGRATIVE FAMILY CARE, PLLC

TODAYS DATE _____
SOC. SEC. # _____

PLEASE PRINT SEX: M F

PATIENT NAME: LAST_____ FIRST_____ M.I._____ DOB_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

EMPLOYER/ OCCUPATION_____EMAIL_____

MARITAL STATUS_____
SPOUSE'S NAME_____DOB_____ SOC. SEC. #_____
SPOUSE'S EMPLOYER/ OCCUPATION _____

CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____
EMERGENCY CONTACT PHONE # _____
How did you hear about our office? _____

If we have scheduled an appointment time for you and you are unable to keep this appointment, please give us a 24 hours advance notice. Failure to do so may result in a $25.00 missed appointment charge.

--FINANCIAL RESPONSIBILITY--

As a medical care provider, our relationship is with you and not with your insurance company (with the exception of valid workman's comp claims). You must realize that some insurance companies do not cover certain services, all charges then are your responsibility. It is also illegal for us to waive deductible and copays specified by your insurance company. Thank you for your understanding and cooperation in the matter.

_____ _____
PATIENT SIGNATURE **DATE**

--INSURANCE INFORMATION—

PRIMARY INSURANCE_____ SUBSCRIBER NAME_____

RELATIONSHIP TO PATIENT_____ POLICY #_____ GROUP#_____

BIRTHDATE_____ SOC. SEC. # _____

SECONDARY INSURANCE_____SUBSCRIBER NAME_____

RELATIONSHIP TO PATIENT_____ POLICY #_____ GROUP#_____

BIRTHDATE_____ SOC. SEC. # _____

--INSURANCE RELASE—

I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby certify that I have provided my complete insurance information. I also understand it is my responsibility to notify Integrative Family Care, PLLC when any change occurs with my insurance coverage.

I request payment of authorized Medicare, Blue Cross or independent insurance benefits be made either to me or on my behalf to Integrative Family Care, PLLC for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits or the benefits payable for the related services.

SIGNED_____ DATE_____

INTEGRATIVE FAMILY CARE PLLC

HIPAA/ RELEASE (for private use, not providers.)

PRINT NAME_____ DOB_____

By signing this form, I acknowledge that I have been offered and/ or received the Integrative Family Care PLLC Notice of Privacy Practices.

Signature of Patient_____ Print Name_____

Date_____ Time_____

Consent of Legal Guardian, Parent Advocate, or nearest relative, if patient is unable to sign or is a minor.

Signature of Guardian, Parent Advocate, or nearest Relative_____

Date_____ Time_____ Relationship_____

Address_____ Phone Number_____

Signature of Witness_____

I authorize any associate of Integrative Family Care PLLC to disclose or release any of my Private Health information to the following persons:

_____ No one other than my self – I can be reached here:

Phone Number_____

_____

_____ Spouse (Name)_____

Phone Number_____

_____

_____ Other (Name)_____

Phone Number_____

_____

I authorize this office to call and confirm scheduled appointments one to two days in advance and to leave a message on home voicemail/recorder or with another family member.

I will provide written notice when I choose to revoke any of the above.

Signature_____ Date_____

Witness_____

INTEGRATIVE FAMILY CARE PLLC
52915 MOUND RD
SHELBY TOWNSHIP, MI 48316

PH: 586-210-3200
FX: 586-210-3300

HIPAA Privacy and Release of Information Authorization

I, _____(print pt. name) hereby authorize INTEGRATIVE FAMILY CARE PLLC and it's affiliates, it's employees and agents to use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/ organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization.

_____

Patient Printed Name Date

_____

Patient Signature or Parent/ Guardian Signature

Informed Consent for Integrative Medical Treatment

As a patient I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as wether or not to undergo care having had the opportunity to discuss potential benefits, risks, and hazards.

I hereby request and voluntarily consent to examination and treatment with integrative medical care, possibly including homeopathic medicines, vitamins, minerals, supplements, injections, detoxification treatment modalities, lab testing, nutrition recommendations, etc. for me (or for the patient nambed below, for whom I am legally responsible) by the licensed medical providers at Integrative Fmaily Care. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

I understand that the U.S. Food and Drug Administration has not fully evaluated or approved nutritional, herbal and homeopathic supplements, bioidentical hormone replacement therapies; however they have been widely use in Europe and the United States for years. I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, and injections may exhibit some side effects in certain sensative individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to certain pre-existing disease conditions. I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judement in recommending the dietary supplements, medications and treatments, that the medical provider feels at the time, based on the facts then know,is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

It is my responsibility to keep my medical providers up to date with all of the current medications and supplements that I am taking, so that he/she can make the best informed recommendatrions for my care. I have the opportunity to ask questions and discuss with my provider to my satisfication:

- My suspected diagnosis or condition.

- The naturem purpose, and potential benefit of proposed care.

- The inherited rissks and complications, potential hazards, or side effects of the treatment or procedure.

- The probability or likelihood, of success.

- Reasonable available alternatives to the proposed treatment or procedure.

- The possible consequences if treatment or advise is not followed and/or nothing is done.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I understand that integrative medicine evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, odering diagnostic imaging, precription of certain medications and nutritional supplements, bio-identical hormone replacement therapy, injections, counseling, dietary therapies, and homeopathic or other alternative remedies. I understand that the medical providers at Integrative Family Care have been trained in diverse range of diagnostic and treatment options. I understand that integrative medicine is highly specialized and based upon evidence-based medicine, including functional medicine and holistic principles. As such, they may recommend different tests; may interpret standard tests differently; may propose different treatments, or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Disgnosis and treatment may include services that are considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and integrative medicine.

By signing this form, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Integrative Family care and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire sourse of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my physician for a more detailed explination. I understand that I have the right to withdraw my consent at any time, with written notice.

_____

PRINT PATIENT NAME

_____

SIGNATURE OF PATIENT (OR GUARDIAN)

DATE SIGNED: _____