INTEGRATIVE FAMILY CARE PLLC

CHILD HISTORY QUESTIONNAIRE

FORM COMPLETED BY:_____ DATE_____ CHILD'S NAME_____
PREFERRED PHARMACY:_____BIRTH DATE_____AGE_____

HOUSEHOLD

M F

PLEASE LIST ALL THOSE LIVING IN THE CHILD'S HOME.

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

ARE THERE SIBLINGS NOT LISTED? IF SO, PLEASE LIST THEIR NAMES, AGES AND WHERE THEY LIVE._____

_____

IF MOTHER AND FATHER ARE NOT LIVING TOGETHER OR IF CHILD DOES NOT LIVE WITH PARENTS, WHAT IS THE CHILD'S CUSTODY STATUS?

_____

IF ONE OR BOTH PARENTS ARE NOT LIVING IN THE HOME, HOW OFTEN DOES HE/ SHE SEE THE PARENT/ PARENTS NOT IN THE HOME?

_____

BIRTH HISTORY

BIRTH WEIGHT_____ WAS THE DELIVERY VAGINAL OR CESAREAN WAS THE BABY BORN AT TERM?_____EARLY?_____LATE_____?

IF CESAREAN, WHY?_____ IF EARLY, HOW MANY SEEKS GESTATION?_____

DID YOUR BABY HAVE ANY PROBLEMS RIGHT AFTER BIRTH? YES NO EXPLAIN_____

WAS INITIAL FEEDING BREAST BOTTLE DID YOU BABAY GO HOME WITH MOTHER FROM THE HOSPITAL? YES NO EXPLAIN

_____

_____

DID MOTHER HAVE ANY ILLNESS OR PROBLEM WITH HER PREGNANCY? YES NO EXPLAIN_____

DURING PREGNANCY DID MOTHER: SMOKE YES NO -- DRINK ALCOHOL YES NO

USE DRUGS OR MEDICATIONS YES NO WHAT_____ WHEN_____

GENERAL

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? YES NO EXPLAIN_____

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITION? YES NO EXPLAIN_____

HAS YOUR CHILD HAD SERIOUS INJURIES OR ACCIDENTS? YES NO EXPLAIN_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO EXPLAIN_____

IS YOUR CHILD ALLERGIC TO ANY MEDICINES OR DRUGS? YES NO EXPLAIN_____

IS YOUR CHILD ON ANY MEDICATIONS OR SUPPLEMENTS? YES NO EXPLAIN_____

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CHILD HISTORY QUESTIONNAIRE

DEVELOPMENT

ARE YOU CONCERNED ABOUT YOUR CHILD'S PHYSICAL DEVELOPMENT? YES NO EXPLAIN_____

ARE YOU CONCERNED ABOUT YOUR CHILD'S MENTAL OR EMOTIONAL DEVELOPMENT? YES NO EXPLAIN_____

ARE YOU CONCERNED ABOUT YOUR CHILD'S ATTENTION SPAN? YES NO EXPLAIN_____

IF YOUR CHILD IS IN SCHOOL:

HOW IS HIS/ HER BEHAVIOR? _____

HAS HE/ SHE FAILED OR REPEATED A GRADE IN SCHOOL? _____

HOW IS HE/ SHE DOING IN ACADEMIC SUBJECTS? _____

IS HE/ SHE IN SPECIAL OR RESOURCE CLASSES? _____

FAMILY HISTORY

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING:	X YES	X NO	WHO	COMMENTS
DEAFNESS				
NASAL ALLERGIES				
ASTHMA				
TUBERCULOSIS				
HEART DISEASE (BEFORE 50 YRS OLD)				
HIGH BLOOD PRESSURE (BEFORE 50 YRS OLD)				
HIGH CHOLESTEROL				
ANEMIA				
BLEEDING DISORDER				
LIVER DISEASE				
KIDNEY DISEASE				
DIABETES (BEFORE 50 YRS OLD)				
BED-WETTING (AFTER 10 YRS OLD)				
EPILEPSY OR CONVULSIONS				
ALCOHOL ABUSE				
DRUG ABUSE				
MENTAL ILLNESS				
MENTAL RETARDATION				
IMMUNE PROBLEMS, HIV OR AIDS				

ADDITIONAL FAMILY HISTORY:

INTEGRATIVE FAMILY CARE PLLC

CHILD HISTORY QUESTIONNAIRE

PAST HISTORY OF CHILD

DOES YOUR CHILD HAVE OR HAS HE/ SHE EVER HAD:	X YES	X NO	EXPLAIN
CHICKENPOX			WHEN:
FREQUENT EAR INFECTIONS			
PROBLEMS WITH EARS OR HEARING			
NASAL ALLERGIES			
PROBLEMS WITH EYES OR VISION			
ASTHMA, BRONCHITIS OR PNEUMONIA			
ANY HEART PROBLEM OR HEART MURMUR			
ANEMIA OR BLEEDING PROBLEM			
BLOOD TRANSFUSION			
FREQUENT ABDOMINAL PAIN			
CONSTIPATION REQUIRING DOCTOR VISITS			
BLADDER OR KIDNEY INFECTION			
BED-WETTING (AFTER 5 YRS OLD)			
(FOR GIRLS) HAS SHE STARTED HER MENSTRUAL PERIODS?			
(FOR GIRLS) ARE THERE PROBLEMS WITH HER PERIODS?			
ANY CRONIC OR RECURRENT SKIN PROBLEM (ACNE, ECZEMA, ETC)			
FREQUENT HEADACHES			
CONVULSTIONS OR OTHER NEUROLOGIC PROBLEM			
THYROID OR OTHER ENDOCRINE PROBLEM			
DIABETES			
ANY OTHER SIGNIFICANT PROBLEM			
USE OF ALCOHOL OR DRUGS			
SMOKE TOBACCO/ VAPE			

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: _____