New Life
Functional Medicine

Date: _____

Patient Demographics & Consent

Please complete these forms and return to us using one of the following three options.

1. E-mail to: info@newlifefunctionalmedicine.com.
2. Mail to: New Life Functional Medicine, 1000 Lake St Louis Blvd., Suite 136, Lake St Louis MO 63367.
3. Fax to: 636.898.1033

_____

Last name, First Name, Middle Initial | Date of Birth | Age | Gender

_____

Street Address | City | State | Zip | Telephone Number

_____

E-Mail Address (used to send test results, etc.) | Alternate Telephone Number

_____

Marital Status | Spouse's/Partner's Name | Spouse's/Partner's Telephone Number

_____

Emergency Contact Name | Relationship to You | Emergency Telephone Number

_____

Pharmacy Name | Pharmacy Telephone Number

_____

Driver's License Number (required for some prescriptions)

_____

Employer | Occupation

_____

Insurance Carrier | Member ID Number | Group Number

Do you have Medicare or Medicaid (even if you don't use it)? ☐ Yes ☐ No

Welcome to New Life Functional Medicine! We want to get to the root cause of your health and wellness concerns and fix the problems "up stream" rather than giving medications for each symptom. So, instead of treating the headache with medicine first, we try to determine the CAUSE of the headache and fix that. We do this with generous appointment times that include a thorough medical history, specialty labs and assistance with diet and lifestyle changes. If needed, medications, supplements and bio-identical hormone therapy can be part of the treatment plan.

We believe each patient is unique, having different lifestyles, belief systems and budgets. Our mission is to help each patient reach achievable goals for their health, lifestyle and budget.

Please note, we may use an alternative to the FDA approved treatments to improve your health. We focus on dietary and lifestyle guidance, as well as advanced laboratory monitoring that is science based, but has not been evaluated by the FDA. I will refer you to your primary care provider if you prefer only FDA approved treatments for your health concerns. Additionally, I will not replace your primary care provider and do not offer 24-hour a day urgent care. My office hours are by appointment only. My scope of practice includes reproductive and functional medicine only, and I will let you know if any of the concerns we discuss should be addressed by your primary care provider.

This office values your privacy and follows all terms and conditions of the Health Insurance Portability and Accountability Act (HIPAA). In doing so, you will be asked to designate, in writing, with whom we can share your private health information. Additionally, our staff is committed to providing care to all patients, regardless of race, skin color, national origin, age, sex, sexual orientation, disability, religious or political beliefs, with dignity and compassion.

Our office will use the contact information you provided to communicate with you during your treatment. This may include personal health information. By signing this consent, you agree to allow us to reach you at the address, phone number and email address you provided above to discuss your care. Please ensure you provide us with a private and secure email address.

_____ Initial here

Consent to Treat:

My signature on this document authorizes the staff of New Life Functional Medicine to perform examinations, order and interpret diagnostic tests, suggest treatments and/or therapies and take other actions that they consider medically necessary to diagnose and treat my symptoms or illnesses. I further understand the practitioner treating me will consult and educate me on the suggested treatment(s) or therapy(s) before proceeding. I understand that the practice of healthcare is not an exact science and that no guarantees will be made to me as to the results or outcomes of my evaluations or treatments.

Financial Policy:

Please be advised that our office is not contracted with any insurance carriers. It is your financial responsibility to pay our fees at the beginning of each visit.

If any lab work is ordered, you will be given a lab order for Quest Diagnostics, which is our lab of choice. It is your responsibility to verify that your insurance will pay for the lab work that is being ordered prior to going to the lab. If you are unsure if your insurance will pay for specific lab work, or if you have a large deductible plan, we offer an option that allows you to pay us directly or labs from Quest at a discounted rate. We require payment in full for this option prior to sending you the lab order.

Your insurance may require that you go to a lab other than Quest. It is your responsibility to know this prior to having any lab work done. The lab order we provide you for Quest can be used at other labs if you are billing through your insurance.

Since we do not accept insurance, we cannot pre-certify any labs or procedures (e.g., pellets) with your insurance company.

_____

Printed Name Signature Date

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Medical & Social History

_____

Last name, First Name, Middle Initial **Date of Birth** **Today's Date**

Reason for today's visit?

_____

_____

_____

What health goals can I help you achieve?

_____

_____

_____

Health problems you are currently being treated for:

_____

_____

_____

_____

Name and specialty of any other healthcare providers you are currently seeing:

_____

_____

_____

Printed Name:_____

Current medications and supplements:

Name	Dosage	Directions	How long?

Major hospitalizations or surgeries and approximate date:

_____

_____

_____

_____

Printed Name:_____

Current method of contraception (e.g., vasectomy, tubal ligation, hysterectomy, IUD (include type), menopause (more than one year without a period), etc. *DO NOT LEAVE BLANK*

_____

_____

For female patients: Do you (or did you prior to menopause) have heavy periods and/or irregular bleeding? If so, what was done about this?

_____

_____

Allergies to medications, foods or other items (such as peanuts, gluten, latex etc):

_____

_____

Who referred you to New Life Functional Medicine?

_____

Preventative tests and approximate date:

- ☐ Full physical exam:_____
- ☐ Bone density: _____
- ☐ Colonoscopy: _____
- ☐ Coronary Calcium Score: _____
- ☐ Mammogram: _____
- ☐ Pap smear: _____
- ☐ Pelvic ultrasound: _____
- ☐ Prostate exam: _____
- ☐ Upper endoscopy: _____

Habits:

- ☐ Do you follow a specialized diet? _____
- ☐ Smoking history: _____
- ☐ Average alcohol intake weekly: _____
- ☐ Current exercise program: _____
- ☐ Height/current weight/goal weight: _____
- ☐ Sleep/rest:
  - Average # of hours each night? _____
  - Describe overall quality of sleep: _____

Printed Name:_____

Personal Health History:

- ☐ Arthritis
- ☐ Anxiety
- ☐ ADD
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Autoimmune Disease
- ☐ Bipolar Disease
- ☐ Blood Clot History or Disorder
- ☐ Blood Pressure Problems
- ☐ Bronchitis
- ☐ Cancer – type: _____
- ☐ Chemical Sensitivity
- ☐ Depression
- ☐ Diabetes – Type I or Type II: _____
- ☐ Eczema
- ☐ Food Allergies
- ☐ Fibromyalgia
- ☐ Genetic Disease
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Immune Disease
- ☐ Infection
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disabilities
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Seasonal Affective Disorder
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infections

Men:

- ☐ Completed child bearing? Y or N
- ☐ Decreased Sex Drive
- ☐ Erectile Dysfunction
- ☐ Prostate Disease
- ☐ Urinary Dysfunction
- ☐ Other:_____

Women:

- ☐ Completed child bearing? Y or N
- ☐ Date of Last Menstrual Period: _____

If still cycling:

- ☐ Length of cycle? _____
- ☐ Heavy cycles
- ☐ Irregular Bleeding
- ☐ Form of Contraception?_____
- ☐ Decreased Sex Drive
- ☐ Endometriosis (now or in the past)
- ☐ Pelvic Pain (now or in the past)
- ☐ Uterine Fibroids (now or in the past)
- ☐ Other: _____

Family Health History (include who & their age):

- ☐ Alzheimer's Disease_____
- ☐ Cancer – type:_____
- ☐ Diabetes – type:_____
- ☐ Heart Disease:_____
- ☐ Osteoporosis:_____
- ☐ Parkinson's Disease:_____
- ☐ Stroke:_____
- ☐ Thyroid Disorder:_____
- ☐ Other:_____

Printed Name:_____

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Acknowledgement of Notice of Privacy Practices Form

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time. I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

For Office Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

Completed by	
Signature of Office Representative	
Date	

New Life
Functional Medicine

Authorization for Release of Protected Health Information Form

Revocation	
Date Revoked	
Initials of HIPAA Compliance Officer	

Patient Name: _____

Date: _____

I authorize New Life Functional Medicine to use or disclose my health information as described below.

1. **Type of information**: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

☐ The entire health record (all information)	
☐ Medication and treatment records	☐ Progress notes
☐ Care plan	☐ Reports from lab or other diagnostic tests
☐ Informed consent	☐ History, exams and other records
☐ Other: (describe as specifically as possible)	

2. **Recipient of information**: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name		Name	
Address		Address	
Phone Number		Phone Number	
Email		Email	

Authorization for Release of Protected Health Information Form

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to an office staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless I specify differently, this authorization will expire (insert date or event):

   _____

4. I understand that the practice will not condition the provision of treatment or payment on the provision of this authorization.

☐ I do not authorize New Life Functional Medicine to release my protected health information.

By signing below, I agree that staff at New Life Functional Medicine may contact me by text, e-mail or phone.

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	