Office Use:
Account # _____

Confidential Patient Information

Full Name _____ Called Name _____ Date _____

Address (Street, City, State, Zip) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Gender _____ Marital Status _____ Date of Birth _____ Social Security # _____

Name of Spouse/Significant Other _____ May we share health info with them? Yes/No

Children's Names and Ages _____

In Case of Emergency Contact _____ Cell and Home # _____

Occupation _____ Employer _____

Known Allergies _____ Pharmacy Name and Number _____

Current/Recent Physicians

Name	Type	Number	Last Seen

Past Medical History

Have you had any major illness, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates): _____

_____

Surgical Procedures

Date	Procedure	Physician	Hospital	Notes

Females only: What was the date of your last menstrual period? _____ Are you pregnant? _____

In the last year, what conditions have you been treated by a physician for? _____

_____

Please list any other health problems/hospitalizations you have had. _____

_____

Current Complaint History

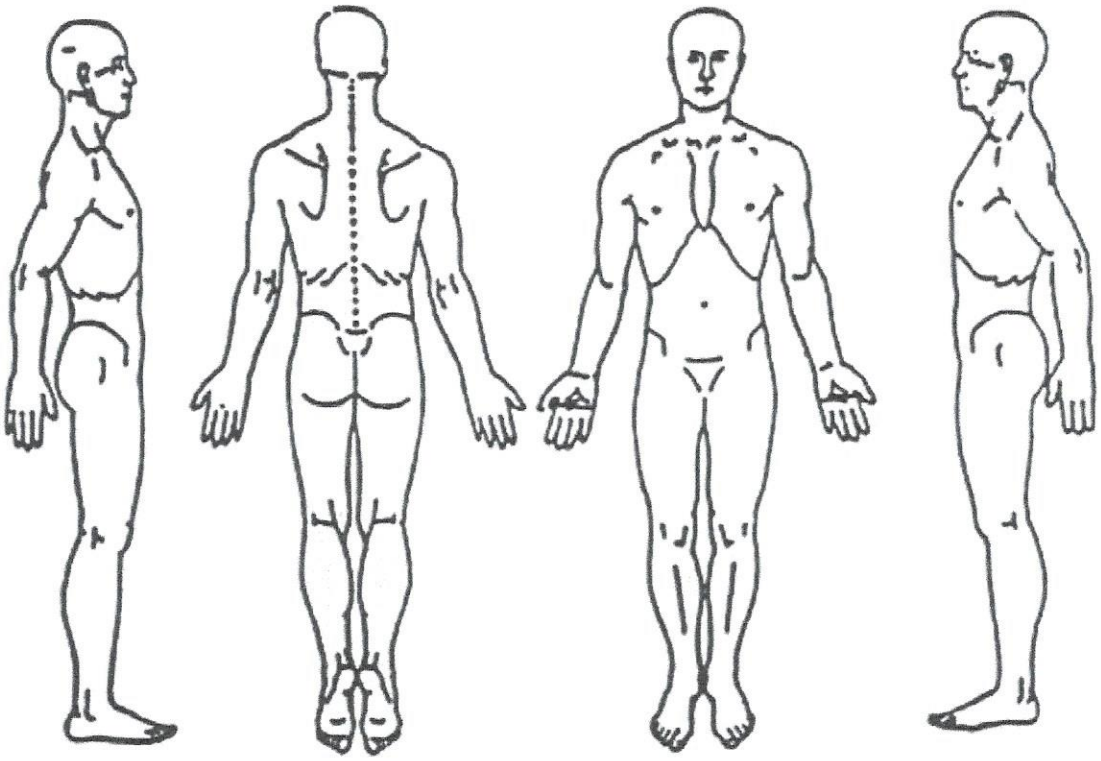
What brings you into the office? _____

_____

_____

Have you ever had similar issues? _____ Explain: _____

Please indicate below where you are experiencing concerns.



Place an "X" on the line below to indicate the level of the problem.

(No Symptoms) 1——————————————————————10 (Extreme Symptoms)

What have you done or used to get relief? _____

_____

What are your expectations for this visit? _____

_____

List any vitamins, herbs, or supplements you take. _____

_____

List any medications you take including dosage. _____

_____

Check the following conditions that apply to you, past and present. Add comments for clarification as needed.

Musculoskeletal
- □ Headaches
- □ Joint Stiffness/Swelling
- □ Spasms/Cramps
- □ Strains/Sprains
- □ Neck Pain
- □ Upper/Mid Back Pain
- □ Low Back Pain
- □ Shoulder, Neck, Arm, Hand Pain
- □ Hip, Leg, Foot Pain
- □ Chest/Rib Pain
- □ Numbness/Weakness
- □ Problems Walking
- □ Jaw Pain/TMJD
- □ Tendonitis
- □ Bursitis
- □ Arthritis
- □ Osteoporosis
- □ Scoliosis
- □ Bone or Joint Disease
- □ Other_____

Circulatory/Respiratory
- □ Dizziness
- □ Shortness of Breath
- □ Fainting
- □ Cold Hands/Feet
- □ Cold Sweats
- □ Chills
- □ Swollen Ankles
- □ Difficulty Lying Flat
- □ Pressure Sores
- □ Varicose Veins
- □ Blood Clots
- □ Heart Conditions/Chest Pain
- □ Palpitations
- □ Allergies
- □ Sinus Problems
- □ Asthma
- □ Cough
- □ Coughing Blood
- □ Wheezing
- □ Excessive Bleeding
- □ Pace Maker
- □ Lymphedema
- □ Other_____

Skin
- □ Rashes
- □ Itching/Burning
- □ Hives
- □ Eczema
- □ Athlete's Foot
- □ Warts
- □ Moles
- □ Acne
- □ Cosmetic Surgery
- □ Other_____

Gastrointestinal
- □ Gum Bleeding
- □ Nervous Stomach
- □ Indigestion
- □ Heartburn/Reflux
- □ Nausea/Vomiting
- □ Change in Bowel Patterns/IBS
- □ Constipation
- □ Diarrhea
- □ Jaundice
- □ Abdominal Pain
- □ Gall Bladder Problems/Removal
- □ Diverticulitis
- □ Crohn's Disease
- □ Colitis
- □ Other_____

Nervous/Eyes/ENT
- □ Numbness/Tingling
- □ Loss of Strength/Weakness
- □ Paralysis
- □ Twitching
- □ Chronic Pain
- □ Sleep Disorders
- □ Ulcers
- □ Herpes/Shingles
- □ Cerebral Palsy
- □ Epilepsy/Seizures
- □ Chronic Fatigue Syndrome
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Parkinson's Disease
- □ Difficulty Hearing
- □ Ringing in the Ears
- □ Eye Correction
- □ Double Vision
- □ Cataracts
- □ Other_____

Reproductive/Urinary
- □ Burning on Urination
- □ Nighttime Urination
- □ Blood in Urine
- □ Erectile Dysfunction
- □ Prostate Problems
- □ Abnormal Discharge
- □ Yeast Infection
- □ Bladder Leakage
- □ Pregnancy
  - □ Current □ Previous
- □ PMS
- □ Menopause
- □ Pelvic Inflammatory Disease
- □ Endometriosis
- □ Hysterectomy
- □ Fertility Concerns
- □ Other_____

Other
- □ Loss of Appetite
- □ Forgetfulness/Memory Loss
- □ Confusion
- □ Depression
- □ Anxiety
- □ Weight Loss/Weight Gain
- □ Fatigue
- □ Fever
- □ Loss of Hair
- □ Hot/Cold Intolerance
- □ Difficulty Concentrating
- □ Hearing Impaired
- □ Visually Impaired
- □ Eating Disorder
- □ Diabetes
- □ Fibromyalgia
- □ Post/Polio Syndrome
- □ Cancer
- □ Rheumatoid Arthritis
- □ Infectious Disease_____
- □ Congenital/Acquired Disabilities_____
- □ Surgeries_____
- □ Other_____

Height	Weight

Comments:_____

Social History

Do you drink alcohol? _____ If yes, what type and amount per week? _____

Do you use tobacco or smoke? _____ If yes, what type and amount per day? _____

Did you ever use tobacco or smoke? _____ If yes, for how long and when did you quit? _____

Do you use recreational drugs? _____ If yes, what type and how often? _____

Do you consume caffeine? _____ If yes, what type and amount per day? _____

Do you exercise? _____ Describe: _____

What are your top 5 favorite foods? _____

What do you typically drink for beverages throughout the day? _____

What time do you go to bed? _____ How much do you sleep per night? _____ What position do you sleep in? _____

What are your hobbies? _____

How many hours per day do you perform the following? Lifting _____ Sitting _____ Bending _____ Computer Use ____

Do you experience an abnormally high amount of stress? If yes, from what? _____

Are you truly ready for change? _____ If no, what is holding you back and what support do you need to achieve your goals? _____

Family History

Are you adopted? _____ If yes, can you fill out the following concerning your *natural* parents? If not, mark N/A.

Is your father alive? If yes, how old? _____ If no, what was the cause of death and age at death? _____

Is your mother alive? If yes, how old? _____ If no, what was the cause of death and age at death? _____

Is there any disease or illness in your family? (parents, siblings, children, aunts, uncles, grandparents) _____

If yes, list what they are and who suffered(s) from them. _____

In particular, does anyone have: (If yes, write "F" for father, "M" mother, "S" Sister, "B" Brother.)

____ Heart Disease	____ Lung Disease	____ Liver Disease	____ Kidney Disease
____ Cancer	____ Stroke	____ Diabetes	____ Asthma
____ Tuberculosis	____ Arthritis	____ Chronic Pain	____ Headaches
____ Scoliosis	____ Trouble Sleeping	____ Mental Illness	____ Other: _____

I understand that I am responsible for all costs of care incurred at Cape Integrative Care, as determined by my treating healthcare provider(s). Any fees for professional services will be immediately due and payable. I understand and agree to allow Cape Integrative Care to use information in this form for the purpose of diagnosis, treatment, payment, healthcare operations, and coordination of care. Cape Integrative Care has made me aware that this patient health information is going to be used in Cape Integrative Care and my rights concerning the privacy of said information is safeguarded. I have read and accept HIPAA NOTICE. I am not on this visit, or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation. I am aware Cape Integrative Care is a Private Membership Association.

Patient or Guardian Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Cape Integrative Care has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

Cape Integrative Care- Medical Weight Loss & Family Practice

HIPPA Notice of Privacy Practice

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPPA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience. The full Practice Privacy Policy and Assignment of Benefits Agreement is available here for you to read or you can ask for your own copy.

This Notice of Privacy Practice describes the ways we are allowed by law to use your protected information (medical records) or PHI to carry out treatment, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your provider will use your PHI as he/she has always done for treatment, payment, or other health care operations. In addition we may also disclose you PHI from time to time to other providers or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. Front desk sign in sheets will be used where you will be asked to sign your name and we will call you by name in the waiting room when your provider is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us, including billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your provider will try to obtain your consent as soon as possible. Your PHI may be disclosed to a public health agency or law enforcement as needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI for purposes of treatment, payment or health care operations, also that it not be disclosed to family members. This must be specific and in writing. However, you provider is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know whom we have revealed your information if it is other than for treatment, payment, or healthcare operations.

You have the right to a paper copy of this notice upon request. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing such a complaint.

By signing this form, you authorize all medical service sources and healthcare providers to use and/or disclose the PHI for treatment and care. In addition, you authorize the disclose of information regarding billing, condition, treatment, and prognosis to the following individuals, all of whom collaborate under Cape Integrative Care- Medical Weight Loss & Family Practice: Ashley Uchtman, Holistic Provider; Kendrick Morris, Healthcare Provider; Debbie Evans, Healthcare Provider; Laura Murphy, Healthcare Provider; Mark Kasten, Healthcare Provider; Susan Anglin, Facial Specialist

Individual(s) listed below are authorized to receive medical information:

_____

_____

_____

Signature_____ Date_____

(Revised 03/15/19)