

## Patient information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Address: (street) \_\_\_\_\_

Home phone number: \_\_\_\_\_ (city, state, zip) \_\_\_\_\_

Cell phone number: \_\_\_\_\_ Best number to reach you: (H) (C) (W)

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

## **Accident Information**

Is this visit due to an accident or injury?  Yes  No If yes, what type?  Auto  Work  Other Injury

If Auto or Work, has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## **Insurance Information**

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Relationship to you (if not yourself): \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## **Assignment and Release (insured patients):**

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**RECEIPT OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices of Northstar Integrated Health & Physical Medicine, SC.

I wish to receive a paper copy of Privacy Notice.

I wish to receive an electronic copy of Privacy Notice.

My email address is: \_\_\_\_\_

I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

*Please initial below:*

(x) \_\_\_\_\_ I acknowledge that it is the policy of Northstar Integrated Health & Physical Medicine, SC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

(x) \_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Vicky Saleg, about my concerns.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness (Office Staff): \_\_\_\_\_ Date: \_\_\_\_\_

## Financial Policy

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. It is the patient's responsibility to pay their co-payment (usually a percent or fixed amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts Credit/Debit Cards, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation with our financial policy.

I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **PATIENT MISSED APPOINTMENT POLICY**

It is our wish that each and every one of our patients receive the highest quality of care and service possible.

Providing the best possible care gives our patients the best possible results and allows them to enjoy best quality of life. Your Treatment Program consists of a specific series of treatments given over a pre-planned time period. Quite simply, if you are unable to follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice by providing less than optimal care and it would also suggest that we did not care about the outcome of your treatment. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

- 1. Meet all your appointments. Arrange the activities in your life so that this can occur.*
- 2. If you become ill, we still want you to come in. Physical Medicine Treatments will help you recover more quickly and we would be happy to provide any general medicine treatment that may be necessary as well.*
- 3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.*
- 4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.*
- 5. All cancelled or missed appointments must be rescheduled and made up within one week.*
- 6. There is a \$20.00 service charge for no call/no show appointments.*

***I have read, understand, and agree to follow the above policy.***

**Patient's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Staff Witness:** \_\_\_\_\_

## **REVIEW OF SYMPTOMS**

Check (✓) those items that applied to you in the *past*. Circle those that *presently* apply

### **General**

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Sleepwalker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted vision

### **SKIN:**

- Cuts heal slowly
- Bruise easily
- Rashes
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness/cracking skin
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Bumps on back of arms & front of thighs
- Skin cancer
- Strong body odor

### **Is your skin sensitive to:**

- Sun
- Fabrics
- Detergents
- Lotions/Creams

### **HEAD:**

- Poor Concentration
- Confusion
- Headaches:
- After Meals
- Severe
- Migraine
- Frontal
- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Eating Sweets
- Concussion/Whiplash
- Mental sluggishness
- Forgetfulness
- Indecisive
- Face twitch
- Poor memory
- Hair loss

### **EYES:**

- Feeling of sand in eyes
- Double vision
- Blurred vision
- Poor night vision
- See bright flashes
- Halo around lights
- Eye pains
- Dark circles under eyes
- Strong light irritates
- Cataracts
- Floaters in eyes
- Visual hallucinations

### **EARS:**

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss

- Itching
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

**NOSE/SINUSES**

- Stuffy
- Bleeding
- Running/Discharge
- Watery nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- Spring
- Summer
- Fall
- Winter

**MOUTH:**

- Coated tongue
- Sore tongue
- Teeth problems
- Bleeding gums
- Canker sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

**THROAT:**

- Mucus
- Difficulty swallowing
- Frequent hoarseness
- Tonsillitis

- Enlarged glands
- Constant clearing of throat
- Throat closes up

**NECK:**

- Stiffness
- Swelling
- Lumps
- Neck glands swell

**CIRCULATION/RESPIRATION:**

- Swollen ankles
- Sensitive to hot
- Sensitive to cold
- Extremities cold or clammy
- Hands/Feet go to sleep/numbness/tingling
- High blood pressure
- Chest pain
- Pain between shoulders
- Dizziness upon standing
- Fainting spells
- High cholesterol
- High triglycerides
- Wheezing
- Irregular heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently sighing
- Shortness of breath
- Night sweats
- Varicose veins/spider veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Prior heart attack ? When \_\_\_/\_\_\_/\_\_\_
- Phlebitis

**GASTROINTESTINAL**

- Peptic/Duodenal Ulcer
- Poor appetite
- Excessive appetite
- Gallstones
- Gallbladder pain
- Nervous stomach
- Full feeling after small meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in bowels
- Rectal bleeding
- Tarry stools
- Rectal itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

**KIDNEY/URINARY TRACT:**

- Burning
- Frequent urination
- Blood in urine
- Night time urination
- Problem passing urine
- Kidney pain
- Kidney stones
- Painful urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

**WOMEN'S HISTORY (for women only)**

- Fibrocystic breasts

- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy periods
- Fibroid Tumors/Uterus

**WOMEN'S HISTORY (for women only)**

- Painful periods
- Change in period
- Breast soreness before period
- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal dryness
- Vaginal discharge
- Partial/total hysterectomy
- Hot flashes
- Mood swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased libido
- Heavy bleeding
- Joint pains
- Headaches
- Weight gain
- Loss of bladder control
- Palpitations

**MEN'S HISTORY (for men only)**

Have you had a PSA done?

Yes \_\_\_\_ No \_\_\_\_

PSA Level:

- 0 - 2
- 2 - 4
- 4 - 10
- >10

- Prostate enlargement

- Prostate infection
- Change in libido
- Impotence
- Diminished/poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty obtaining erection
- Difficulty maintaining an erection
- Nocturia (urination at night)
- How many times at night? \_\_\_\_
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of bladder control

#### **JOINT/MUSCLES/TENDONS**

- Pain wakes you
- Weakness in legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle stiffness in morning
- Damp weather bothers you

#### **Emotional:**

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts/Amnesia
- Had prior shock therapy
- Frequently keyed up and jittery
- Startled by sudden noises
- Anxiety/Feeling of panic
- Go to pieces easily
- Forgetful
- Listless/groggy
- Withdrawn feeling/Feeling 'lost'
- Had nervous breakdown
- Unable to concentrate/short attention span

- Vision changes
- Unable to reason
- Considered a nervous person by others
- Tends to worry needlessly
- Unusual tension

#### **EMOTIONAL (CONTINUED)**

- Frustration
- Emotional numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Previously admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Misunderstood by others
- Irritable/
- Feeling of hostility/volatile or aggressive
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy



Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
<b>INJURIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

<b>DIAGNOSTIC STUDIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
Blood Tests		
Bone Density Test		
Bone Scan		

Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
<b>SURGERIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

### HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

### MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes \_\_\_ No \_\_\_  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

## CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was the last time that you felt well? \_\_\_\_\_

What seems to trigger your symptoms? \_\_\_\_\_

What seems to worsen your symptoms? \_\_\_\_\_

What seems to make you feel better? \_\_\_\_\_

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much time have you lost from work or school in the past year due to these conditions? \_\_\_\_\_

## PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		