Integrative Medicine
Natural Healing Alternatives
& Medical Acupuncture
999 Diamond Ridge
Suite 201
Jefferson City, MO 65109
573-632-5585
Fax: 573-634-2978

Welcome to our Clinic

Attached with this letter is a health history form that will enable the doctor to understand your medical needs. Please complete and mail/fax it to our office. You will need to bring all medications you currently take as well as any/all additional supplements you take. Also, bring your insurance cards and a photo ID.

If you are unable to keep your scheduled appointment, please notify the office at least 48 hours in advance. Plan to arrive for your appointment 30 minutes early.

Please take the time to accurately complete the following questionnaire. Detailed descriptions of your health concerns will help you and your provider to design your treatment plan. Several of the questions are very personal; however, they may be indicative of stressors which can affect your health. All answers will be held in strict confidence. Please answer questions that you are comfortable with.

Thank you for choosing Integrative Medicine to participate in your health and wellness.

Sincerely,

Chris Link, M.D.

Rachel Lenon, FNP-BC

Please review and change any outdated or incorrect information.

PATIENT INFORMATION

Patient Name:	Date of Birth: Age:
Preferred to be called:	Gender:
Previous/Maiden Name:	Marital Status:
Mailing Address:	Social Security #:
	Employer:
City, State, Zip:	☐ Unemployed ☐ Retired ☐ Student
Email: ☐ DO NOT HAVE EMAIL	☐ DO NOT WISH TO SHARE EMAIL ADDRESS

PHONE NUMBERS WHERE WE MAY CONTACT YOU OR LEAVE MESSAGES

Primary #:	Secondary #:	Work #:

RESPONSIBILITY PARTY INFORMATION

Name:	Date of Birth:
Relationship: ☐ Self ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ POA	Social Security #:
Address:	Primary #:
City, State, Zip:	Secondary #:
Employer:	Work #:

OTHER PARENT / GUARDIAN INFORMATION

Name:	Date of Birth:
Relationship: ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Power of Attorney	Social Security #:
Address:	Primary #:
City, State, Zip:	Secondary #:
Employer:	Work #:

DO YOU HAVE AN ADVANCED DIRECTIVE, LIVING WILL OR POWER OF ATTORNEY?

☐ No, I do not have one ☐ Yes, a copy is here ☐ Yes, but copy NOT given ☐ Yes, copy is at the hospital

PHARMACY INFORMATION (LOCAL OR MAIL ORDER)

Primary Pharmacy:	Location:
Alternate Pharmacy:	Location:
Mail Order Pharmacy:	Phone/Fax Number:

INDIVIDUALS THAT WE ARE AUTHORIZED TO SPEAK TO ABOUT YOUR CARE

Emergency Contact :	Phone:	Relationship:

Contact 2:	Phone:	Relationship:
Contact 3:	Phone:	Relationship:
Contact 4:	Phone:	Relationship:

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR CHILD

In addition to custodial parents, the following individuals are authorized to accompany this child to receive medical treatment:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

INSURANCE INFORMATION

Primary Insurance	*Secondary Insurance*	*Tertiary Insurance*
Name:	Name:	Name:
Policy #:	Policy #:	Policy #:
Group #:	Group #:	Group #:
Cardholder Information if not Patient:	Cardholder Information if not Patient:	Cardholder Information if not Patient:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
DOB:	DOB:	DOB:

PATIENT'S RACE, ETHNICITY AND PRIMARY LANGUAGE

Race:	☐ White	☐ Black/African American	☐ Hispanic	☐ Other Pacific Islander	
	☐ Asian	☐ American Indian/Alaska Native	☐ Native Hawaiian	☐ Other Race	
Ethnicity:	☐ Hispanic	Language other than English:	☐ Spanish	☐ Russian	☐ Hindi ☐ Other
	☐ Non-Hispanic	Interpreter Required:	☐ Yes	☐ No	If Yes, Type:

Patient Acknowledgements and Authorizations:

With our environment in mind, complete paper copies of the following policies are available upon request for personal use.

* I acknowledge I have been provided with Capital Region Medical Center's Financial Policy, Notice of Privacy Practices, Patient Bill of Rights and information regarding what is done to prevent the spread of infection and what I can do to prevent infections.
* I acknowledge any patient specimens collected at a Capital Region Physician's Clinic will be processed at Capital Region Medical Center and it is my responsibility to inform the staff if I prefer, or if my insurance requires my specimens to go to a different laboratory for processing.
* I understand I am responsible to pay all costs not covered by insurance. If insurance requires a co-pay, it is to be paid at the time of service. I understand and agree to these terms authorizing payment from insurance carriers be made to Capital Region Medical Center and hereby give my permission to release any information necessary to collect from any third party payers. I verify the information provided is current and correct.
* I, the undersigned, hereby authorize Capital Region Medical Center physicians to examine and to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.
* I understand Capital Region Medical Center utilizes an electronic prescribing network for prescription medications involving participating pharmacies and other health care providers in order to better avoid medication errors and adverse drug interaction and consent that Capital Region Medical Center may view my medication history.
* I authorize representatives of Capital Region Medical Center and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me by using any telephone number(s) supplied by me and may leave messages with whoever answers the phone or the associated recorder using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Signature of the Adult Patient in Agreement to the above Patient Acknowledgements and Authorizations :

× _____ Date: _____

For Patients under 18 years of age or Patients with a Guardian/Power of Attorney:

Signature of the responsible party agreeing to the above Patient Acknowledgements and Authorizations, which includes authorizing medical treatment and responsible for paying any costs not covered by insurance:

×
× _____ Date: _____

Parent / Guardian of Patient

Patient could not sign the acknowledgement because of physical impairment. Patient verbally agreed to the above Patient Acknowledgements and Authorizations.

_____ Date: _____

Staff Signature

Circle of Care

At Capital Region Physicians, our goal is to provide you the most complete care. As we update our new Patient Information System, we would like to record in your health record all providers that participate in your healthcare.

Please list all Physicians, including other Capital Region Physicians, who are actively participating or have participated in in your healthcare during the past year.

Thank you.

Primary Care Physician:

First Name: _____ Last Name: _____

City/ State: _____

Specialists:

Provider First Name: _____ Last Name: _____

City/ State: _____ Specialty: _____

Provider First Name: _____ Last Name: _____

City/ State: _____ Specialty: _____

Provider First Name: _____ Last Name: _____

City/ State: _____ Specialty: _____

Provider First Name: _____ Last Name: _____

City/ State: _____ Specialty: _____

Provider First Name: _____ Last Name: _____

City/ State: _____ Specialty: _____

Patient Name: _____ DOB: _____

Primary Care Provider: _____ **Referring Provider:** _____

Current / Recent medical and other health care providers (Please list names; include physical therapy, psychology, etc.):

_____

_____

List Complementary and Alternative therapies or practitioners you have tried (Please list names):

_____

_____

Please describe your goals and expectations regarding your appointment with Integrative Medicine:

_____

_____

_____

Current Medications; please include a list of prescription and supplement medication names. Attach additional pages if necessary.

Medication Name	**Dosage Amount** (Ex. 15 mg, 2 puffs, 5 meq)	**Take** (Ex. 1 tablet, 2 tablets 1 to 2 tablets)	**Frequency** (Ex. Once a day, Twice a day, as needed)	**Reason for Medication** (Ex. High blood pressure, diabetes, high cholesterol)

***Bring** all medications with you for your first appointment.

Patient's Medical History *(please include detail, if applicable):*

- □ Anxiety
- □ Asthma
- □ Asthma, exercise induced
- □ Bleeding Disorders
- □ Cancer_____
- □ Cirrhosis
- □ Concussion
- □ COPD
- □ Depression
- □ Diabetes
- □ Eczema
- □ Emphysema
- □ Erectile Dysfunction
- □ Fibromyalgia
- □ Gallstones
- □ Glaucoma / Cataracts
- □ Headaches
- □ Heart Attack
- □ Heart Disease
- □ Heart Murmur
- □ Hemorrhoids
- □ Hepatitis
- □ High Blood Pressure
- □ HIV / AIDS
- □ Impotence
- □ Infertility
- □ Migraines
- □ Mitral Valve Prolapse
- □ Nerve Damage
- □ Psoriasis
- □ Rheumatic Fever
- □ Rosacea
- □ Seasonal Allergies
- □ Seizures
- □ Sleep Disorder
- □ Stomach Ulcers
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis
- □ Venereal Disease
- □ Other_____

Patient Name: _____ DOB: _____

Please list year of most recent:

Colonoscopy _____ Stool test _____

Flu Shot _____ Mammogram _____

Pap Smear _____

Psychiatric History*:*

Have you ever been treated for emotional problems? Yes or No

Have you ever considered attempted suicide? Yes or No

Medication Allergies (List Reactions or write unknown): £ No Known Drug Allergies

_____

_____

Surgical History *(Provide dates of procedures):*

_____

_____

Hospitalization *(Excluding from surgery and births; provide dates of admittance and reason):*

_____

_____

Accidents / Trauma *(Describe and provide dates of injuries):*

_____

Other*:*

_____

Family History *(Health Problems or Conditions)****:***

FATHER: □ Living □ Deceased; cause of death: _____ If alive, father's present age_____

MOTHER: □ Living □ Deceased; cause of death: _____ If alive, mother's present age_____

# of Siblings – Brothers _____ Sisters _____ £ Healthy # of Children – Sons _____ Daughters _____ £ Healthy

Mark if applicable any particular health problems your family members have (excluding yourself):

Alive	Deceased	Unknown		Stroke	Diabetes	Heart Disease	Kidney Problem	High Blood Pressure	Bleeding Problem	Stomach Problem	Thyroid Disease	Cancer - type?	Other Health Problem - type?
			Father										
			Mother										
			Maternal Grandparents										
			Paternal Grandparents										
			Sibling(s)										
			Children										
			Other										

Patient Name: _____ DOB: _____

Social History:

Marital Status: £ Single £ Married £ Separated £ Divorced £ Widowed £ Partner £ Child £ Other: _____

_____ # of adults in household _____ # of children in household, ages: _____

Education Level: £ Not completed High School £ High School Graduate £ Some College Hours £ College Graduate

£ Professionals / Masters / PhD £ Technical School Based Training

Describe current state of finances: _____

Describe your religion / spirituality: _____

Hobbies / Volunteer Work (current or previous): _____

_____

Occupation: _____ Occupation Exposure: _____

Exercise regularly? **Yes** or **No** How many times per week? _____ Type: _____

Best way to learn: £ Reading £ Listening £ Visual £ Demonstration £ Other_____

Barriers to learning: £ Language £ Culture £ Hearing £ Permanent Cognitive Impairment £ None

Have you ever, smoked or used tobacco? **No Formerly Currently**

Type: £ cigarettes £ pipe £ chew £ nicotine patch

# of years you have been tobacco free? _____

Did you have a drink containing alcohol in the past year? **Yes** or **No**

Type: £ Wine £ Whiskey £ Beer £ Other: _____

How often do you drink? £ Daily £ Weekly £ Rarely £ Socially £ Occasionally

Have you ever, used recreational drugs? **No Formerly Currently** Type: _____

How many sexual partners have you had in the last year? _____

Women's Menstrual History

GYN History: ____ Age at first period First day of last period: _____

____ # of days between cycles ____ Duration of period ____ Age at menopause

OB History: ____ # of pregnancies ____ # of live births ____ # premature births ____ # of miscarriages/abortions

Other: _____

Additional Notes:

Please inform us if any of the below items have affected you in the past 6 months.

General:

£ Binge eating/ drinking
£ Craving certain foods
£ Excessive weight
£ Compulsive eating
£ Water retention
£ Currently underweight
£ Fatigue , sluggishness
£ Apathy, lethargy
£ Hyperactivity
£ Restlessness
£ Frequent illness
£ Other Concerns_____

Respiratory:

£ Chest congestion
£ Asthma, bronchitis
£ Shortness of breath
£ Difficulty breathing
£ Other Concerns_____

Cardiovascular:

£ Heart rate-irregular, skipped heartbeat
£ Heart rate-fast, pounding
£ Chest pain
£ Other Concerns_____

Head/Eyes/Ears/ Nose/Throat:

£ Headaches
£ Faintness
£ Dizziness
£ Insomnia
£ Swollen or discolored tongue, gums, lips
£ Canker sores
£ Itchy ears
£ Earaches, ear infections
£ Drainage from ears
£ Ringing in ears
£ Hearing loss
£ Watery or itchy eyes
£ Swollen, reddened, or sticky eyelids
£ Bags or dark circles under eyes
£ Blurred or tunnel vision
£ Stuffy nose
£ Sinus problems
£ Hay fever
£ Sneezing attacks
£ Excessive mucous formation
£ Chronic cough
£ Gagging, frequent need to clear throat
£ Sore throat
£ Hoarseness, loss of voice
£ Other Concerns_____

Skin:

£ Acne/pimples
£ Hives, rashes
£ Hair loss
£ Dry skin/ scalp
£ Flushing/ hot flashes
£ Excessive sweating
£ Other Concerns_____

Gastrointestinal:

£ Nausea
£ Vomiting
£ Diarrhea
£ Constipation
£ Bloating
£ Belching, passing gas
£ Heartburn
£ Intestinal/ stomach pains
£ Other concerns_____

Neurological:

£ Poor memory
£ Confusion, poor comprehension
£ Poor concentration
£ Poor physical coordination
£ Difficulty in making decisions
£ Stuttering or stammering
£ Slurred speech
£ Learning difficulty
£ Other concerns_____

Genitourinary:

£ Urinary Frequency
£ Urinary Urgency
£ Genital itch or discharge
£ Other Concerns_____

Psychiatric:

£ Mood swings
£ Anxiety, nervousness
£ Fearful
£ Anger, irritability, aggressiveness
£ Depression
£ Other concerns_____

Musculoskeletal

£ Pain or aches in joints
£ Arthritis
£ Stiffness or limitations of movement
£ Pains or aches in muscle
£ Feeling of weakness or tiredness
£ Other concerns_____

If you are experiencing pain now or having on-going pain please fill out the following section.

Location: _____

Quality: _____

Radiation: _____

What makes it better? _____

What makes it worse? _____

How long have you had it? _____

Mark an X on the line where your pain is currently:

No pain *Excruciating pain*

0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities and sleep:

_____

_____

_____

How would you describe your health (circle one): Poor Average Good

List the things that cause you the most stress in your life now (e.g. relationships, family, health, money, job, etc.) and number them in order of significance

_____ _____

_____ _____

_____ _____

_____ _____

How would you rate your stress level in the past month? Place an X or circle the appropriate spot on the line below:

No Stress *Extremely Stressed*

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month? Place an X or circle the appropriate spot on the line below:

Unhappy *Happy*

0 1 2 3 4 5 6 7 8 9 10

What do you do for relaxation/coping? _____

_____

When do you have the highest energy level?

_____ Morning _____ Afternoons_____ Evenings

When do you have the lowest energy level?

_____ Morning _____ Afternoons_____ Evenings

Please describe how fatigue or low energy affects your daily activities:

_____

_____

Please describe your mood:

_____

_____

Describe your sleep (in general):

_____

_____

Please describe how sleep deprivation affects your daily activities:

_____

_____

-

Diet and Nutrition History:

Do you use coffee/tea? _____ If yes, how much per day? _____

Do you use soda? _____ If yes, how much per day? _____

Are there any types or groups of foods you crave or eat a lot?

_____

Are there any types or groups of foods you dislike or rarely eat?

_____

What do you drink on a typical day?

_____

_____

Recall of dietary intake:

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.

Breakfast: _____

_____

*Lunch:*_____

_____

*Dinner:*_____

_____

Snacks: _____

_____

Is this a typical day? If not, why not? Please describe:

_____

_____

What type of oil do you cook with? _____

What type of spreads do you add to your foods? _____

How many cups (8 oz) of water do you drink on a typical day? _____

How many servings of fruit do you eat on a typical day?

(1 serving = 1 small piece, or ½ cup juice, or ½ cup canned or chopped, or ¼ cup dried)

_____

How many servings of vegetables do you eat on a typical day?

(1 serving = 1 small piece, or 1 cup fresh leafy greens, or ½ cup raw or cooked, or ¼ cup dried)

_____

Please describe your relationship to food:

_____

_____

Highest weight ever:_____Desired weight:_____

Please describe your childhood:

_____

_____

_____

How would you rate your own health as a child? Good Fair Poor

Please list any major traumas (emotional, verbal, physical, and sexual) you have experienced:

_____

_____

_____

Is there any other information that you would like to share with us?

_____

_____

_____

Thank you for taking the time to complete this extensive form. This information will be very helpful in your evaluation and assessment.

We look forward to your visit and working with you to meet your goals.

Please try to keep your appointment. If you are unable to keep your appointment, please allow 48 hours notice. Be aware that it may be several weeks/months to reschedule.

□ *Check this box if you would like for your name to be placed on a cancelation list; please complete and return this form within 2 weeks receipt.*