

Comprehensive Health History Forms

Patient Information

Legal Name: _____ DOB: _____ Age: _____ Sex: M or F
(last) (first) (middle initial)

St Address: _____ City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____ **Best to Reach:** Phone Text Email

Email: _____ SS#(need for Ins Verification): _____

Can we voice record your appointment for training purposes only? Yes or No

Race: American Indian/Alaska Native Asian Black or African American White (Caucasian)
 Native Hawaiian or Pacific Islander Other I Decline to Answer

Ethnicity: Hispanic Non Hispanic I Decline to Answer

Status: Single Married Widowed Divorced Separated Minor

If Patient is a Minor: Parent/Guardian Name: _____ Ph: (_____) _____

Occupation: _____ Employer: _____ Work Ph: (_____) _____

In Case of Emergency: Name: _____ Relationship _____ Ph: (_____) _____

How Did You Hear About Us? Dr Referral _____ Patient Referral _____

Facebook Google Walk-In Health Talk/Event Other: _____

Medical Information

Primary Care Physician's Name _____ Phone: (_____) _____

Clinic Name _____ Fax: (_____) _____

I allow my health progression to be shared with my primary care physician: Yes No

History of Present Illness

What brings you in to the office today (major complaint)? _____

Have you seen a MD/PT or DC for this problem? Yes No

Previous Treatment for this condition: _____

Did it resolve the condition: Yes No Explain: _____

How many years have you had the pain (complaint)? _____

How does this problem interfere with your daily life? _____

Have you considered surgery? Yes No Have you had any Nerve Testing/EMG? Yes, when _____ No

What is your main concern about your complaint(s)? _____

On a Scale from 1 to 10 (10 high), what is your interest in getting help for your (complaint)? 1 2 3 4 5 6 7 8 9 10

List all recent X-ray's, CT Scans and MRI, when and state Results: _____

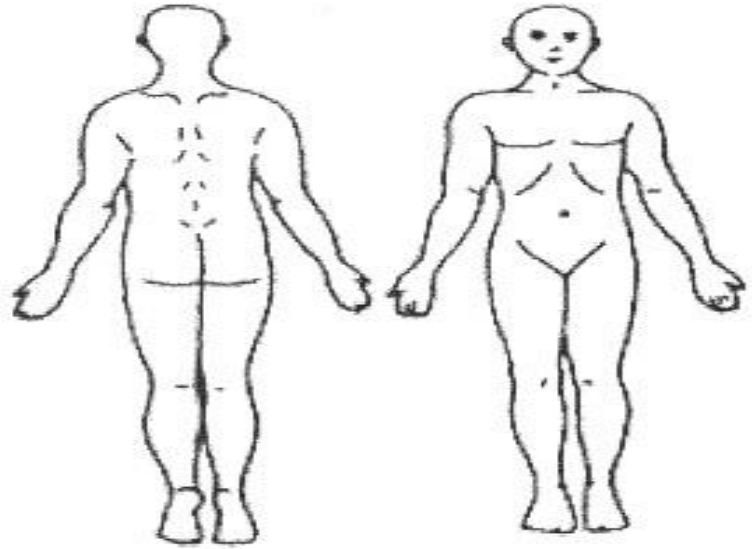
List other current or ongoing health problems in order of priority and your treatments:

1. _____
2. _____
3. _____

Current Condition

Label on the Diagram the CURRENT Areas of Discomfort:

- | | |
|-------------------|-------------|
| A=Aching | B=Burning |
| C=Cold | CR=Cramps |
| D=Dull | H=Hot |
| HY=Hypersensitive | N=Numbness |
| P=Pins&Needles | S=Stabbing |
| SH=Sharp | SP=Spasms |
| ST=Stiffness | SW=Swelling |
| T=Throbbing | TI=Tingling |
| W=Weakness | |



Review of Systems

Check appropriate box and provide date of onset and circle if there are options

= past = ongoing = never

- Anesthesia Problems
- Aneurysm _____
- Blood Clots
Legs / Lungs
- Blood Thinners
- Chest Pain
- Chemical Exposure
Pesticides / Agent Orange
- Constipation / Diarrhea
- COPD
- Cough
Recurrent / Chronic
- Diabetes Type 1 / Type II
- Dizziness
- Emphysema
- Epilepsy
- Fibromyalgia
- GERD
- Gout
- Headaches / Migraines
- Heart Disease / Palpitations
- Hepatitis
- Hernia
- Blood Pressure: High / Low

- High Cholesterol
- HIV
- Kidney Disease
- Lung Disease
- Lupus
- MRSA
- Neuropathy
- Pacemaker/Defibrillator**
- Paralysis
- Plantar Fasciitis
- Polio
- Shingles
- Skin Pigment Changes
- Sleep Apnea
- Spider Veins
- Stroke / TIA
- Swelling Feet/Ankles
- Tuberculosis
- Ulcers / Amputations
- Vascular Disease
- Varicose Veins
- Vitamin Deficiency
B12 or D3

Musculoskeletal

- Arthritis
- Degenerative Disc
- Disc Bulge
- Disc Herniation
- Fusion: _____
- Hernia
- Joint Replacement
- Knee Pain
- Lower Back Pain
- Neck Pain
- Sciatica: R L or Both
- Spinal Fractures
- Spinal Stenosis
- Spinal Arthritis
- Upper Back Pain
- Other

- Other

- Other

- Other

Cancer: Location _____ Year _____

Did you have Radiation? Yes No Chemotherapy? Yes No Medication? Yes, Type _____ No

Family History

Biological Mother Living Deceased: Cause of Death: _____

Relevant Health History: _____

Biological Father Living Deceased: Cause of Death: _____

Relevant Health History: _____

Medical History

Injuries / Accidents

None

Date	Reason

Surgeries

None

Date	Reason

Hospitalizations

None

Date	Reason

Lifestyle History

Check Your Exercise Levels:

Inactive Light Activity Moderate Activity Heavy Activity Vigorous Activity

Please check all that apply:

Current Tobacco User No Yes, Type _____ Amt/Day: _____

Previous Tobacco User No Yes, Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? Yes No

Current Alcohol Drinker No Yes, How many drinks per week? 1-3 4-6 7-10 >10

Previous Alcohol Drinker No Yes, How many drinks per week? 1-3 4-6 7-10 >10

Do you currently or have previously used recreational drugs? No Yes, what types and method (IV, inhaled, smoked, etc.) _____

Work Activity Level:

Full-Time Part-Time Homemaker Student Unemployed

Medication Information

Current Medication (Rx)	Dose / Frequency	Start Date / Reason for Use

Nutritional Supplements (non Rx)	Dose / Frequency	Start Date / Reason for Use

For any additional medications and supplements, please list on additional paper

Have your medications or supplements ever caused unusual side effects or problems? No Yes,
Describe: _____

Do you have any surgical devices or pins/screws in your body? No Yes, Where? _____

List all allergies, intolerances or sensitivities:

Drugs / Medication: None Yes, List: _____

Food: None Yes, List: _____

Environmental/Chemical: None Yes, List: _____

Daily Activities *Effects of Current Condition on Daily Performance*

Please mark for each CURRENT Condition: 1=No Effect 2=Slightly Limited 3=Limited 4=Mostly Limited 5=Unable to Perform

Bending	1 2 3 4 5	Cleaning	1 2 3 4 5	Climbing	1 2 3 4 5
Computer Work	1 2 3 4 5	Concentrating	1 2 3 4 5	Cooking	1 2 3 4 5
Dancing	1 2 3 4 5	Dressing	1 2 3 4 5	Driving	1 2 3 4 5
Jumping	1 2 3 4 5	Lifting	1 2 3 4 5	Playing Sports	1 2 3 4 5
Pushing	1 2 3 4 5	Running	1 2 3 4 5	Sexual Activity	1 2 3 4 5
Sitting	1 2 3 4 5	Sit to Stand	1 2 3 4 5	Sleeping	1 2 3 4 5
Stairs	1 2 3 4 5	Standing	1 2 3 4 5	Walking	1 2 3 4 5
Working	1 2 3 4 5	Vacuuming	1 2 3 4 5	Yardwork	1 2 3 4 5

Accident Information

Is your condition due to an accident? No Yes, Date _____

Type of Accident: Auto Work Home Other _____

To whom have you made a report of your accident? Auto Insurance Employer Work Comp
 Other _____

Attorney Name: (if applicable) _____ Ph: (_____) _____

Insurance Information

Who is responsible for this account? Self Other _____

Name on Account and Relationship _____

Insurance Company: _____ Policy #: _____ Group #: _____

Is the patient covered by a Supplement/Secondary Insurance? Yes No

Name on Account and Relationship _____

Insurance Company: _____ Policy #: _____ Group #: _____

Assignment and Release I understand and agree that (regardless of whatever health or medical benefits I have), I am ultimately responsible to pay LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, for medical services rendered and for any supplies, tests or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. Patient irrevocably assigns all of his/her rights and benefits and right to pursue enforcement of such benefits, under any policy of insurance, indemnity, health plan (including self-funded), or any collateral source to LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, including the right to submit claims for reimbursement and payment for services rendered, and authorizes direct payment to the provider of any benefits otherwise payable to or on behalf of the Patient. Patient assigns to Provider his/her right to pursue payment, appeals, claims, causes of action, penalties, administrative, and/or legal remedies including the right to bring claims under enforcement provisions of ERISA, against any responsible source of payment including but not limited to any insurer, health plan (including self-funded), health carrier, hospital or medical service corporation, ERISA plan or administrator, for any and all benefits due me under my benefit plan. Provider is expressly authorized to bring any and all claims to enforce my rights under ERISA, including right to payment, breach of fiduciary duty, breach of contract, civil penalties, or any other claim or remedy. Provider is authorized to make such claims, institute legal or alternative dispute resolution proceedings, enter into settlements or compromises and any other acts necessary to pursue my rights and benefits. This assignment extends to any affiliates, agents, and/or assignees of Provider. Patient hereby appoints Provider as his/her authorized representative and attorney-in-fact for such activities, and authorizes Provider to take such actions in the name of Provider and/or the Patient. If I receive payment directly from any source for the services I receive from Provider, I agree it is my duty and responsibility to immediately pay any such amounts to Provider.

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Date

We ask that you realize that we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However; the treatment we recommend and the fees we charge **WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.**

LifeWorks

YOUR INTEGRATIVE HEALTH PARTNERSHIP
19701 W 65th Terrace | Shawnee KS 66218
PH: 913.441.2293 | FX: 888.988.2645

Privacy and Billing Consent Form

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, _____ with my signature, authorize LifeWorks Integrative Health and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. LifeWorks Integrative Health is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

LifeWorks

YOUR INTEGRATIVE HEALTH PARTNERSHIP
19701 W 65th Terrace | Shawnee KS 66218
PH: 913.441.2293 | FX: 888.988.2645

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____