

New Patient Packet



Congratulations on your decision to move further on the path to optimal health! We're here to educate and support you as part of our commitment partnering with you in managing your health. The following information is necessary in order for us to optimize your care. Please fill out this form as completely and as accurately as possible.

GENERAL INFORMATION

Name: _____ Preferred Name: _____

Primary Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS #: _____

Age: _____ Gender: Female Male Marital Status: _____

Ethnicity: _____ Race: _____

Home Phone: _____ Preferred Language: _____

Work Phone: _____ Best way to reach you: _____

Cell Phone: _____ Best time to reach you: _____

E-Mail Address: _____

Current Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Address: _____ Apt. No.: _____

City: _____ State/Zip: _____

Current Name: _____ Phone #: _____

Primary Care Physician City: _____

Referred by Name: _____

Primary Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

Insured Name: _____ Relationship: _____

Insured Date of Birth: _____ Insured SS #: _____

Insured Address (if different from patient): _____

Secondary Insurance Co. Name: _____ Phone #: _____

(if applicable)

Company Address: _____

Policy #: _____ Group #: _____

Insured Name: _____ Relationship: _____

Insured Date of Birth: _____ Insured SS #: _____

Insured Address (if different from patient): _____

Person Responsible for Bill: _____ Relationship: _____

Address: _____ Phone: _____

MEDICAL SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile **FOR THE PAST 30 DAYS**
 (if you are dealing with more than one symptom listed below then please circle all that apply):

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

<p>0 <i>Never or almost never</i> have the symptom</p> <p>1 <i>Occasionally</i> have it, effect is <i>not severe</i></p> <p>2 <i>Occasionally</i> have it, effect is <i>severe</i></p>	<p>3 <i>Frequently</i> have it, effect is <i>not severe</i></p> <p>4 <i>Frequently</i> have it, effect is <i>severe</i></p>
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HEAD _____ Headaches
 _____ Dizziness/Faintness
 _____ Insomnia
 _____ **TOTAL (this section)**

EYES _____ Watery or itchy eyes
 _____ Swollen, reddened or sticky eyelids
 _____ Dark circles under eyes
 _____ Vision problems
 (excluding near or farsighted)
 _____ **TOTAL (this section)**

EARS _____ Itchy ears
 _____ Frequent ear infections
 _____ Popping of ears
 _____ Ringing in ears
 _____ **TOTAL (this section)**

NOSE _____ Stuffy nose/Excessive mucus formation
 _____ Sinus problems
 _____ Hay fever/Sneezing attacks
 _____ Nose bleeding
 _____ **TOTAL (this section)**

MOUTH/ _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen/Discolored tongue, gums, lips
 _____ Canker sores
 _____ **TOTAL (this section)**

SKIN _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Excessive hair growth
 _____ Excessive sweating/Body odor
 _____ Flushing, hot flashes
 _____ **TOTAL (this section)**

HEART _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain
 _____ **TOTAL (this section)**

LUNGS _____ Chest congestion
 _____ Asthma, frequent bronchitis
 _____ Difficulty breathing
 _____ Frequent coughing
 _____ **TOTAL (this section)**

DIGESTIVE TRACT _____ Nausea, vomiting
 _____ Diarrhea, loose stools
 _____ Constipation, hard/infrequent stools
 _____ Bloating feeling
 _____ Belching, passing gas, burping
 _____ Heartburn/acid taste in mouth
 _____ Intestinal/stomach pain
 _____ **TOTAL (this section)**

JOINTS / MUSCLE _____ Pain or aches in joints/Arthritis
 _____ Warm, swollen joints
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Muscle weakness
 _____ **TOTAL (this section)**

WEIGHT _____ Excessive eating/drinking
 _____ Strong/Excessive craving certain foods
 _____ Overweight/Obese
 _____ Difficulty losing weight
 _____ Water retention
 _____ Difficulty gaining weight
 _____ **TOTAL (this section)**

ENERGY / ACTIVITY _____ Fatigue from mental exhaustion
 _____ Fatigue from emotional exhaustion
 _____ Hyperactivity (mind or body)
 _____ Restlessness (mind or body)
 _____ **TOTAL (this section)**

MIND _____ Poor memory
 _____ Confusion, poor comprehension
 _____ Poor concentration
 _____ Poor physical coordination
 _____ Difficulty making decisions
 _____ Speech difficulty
 _____ Learning disabilities
 _____ **TOTAL (this section)**

EMOTIONS _____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression/Sadness
 _____ Obsessive, compulsive behaviors
 _____ **TOTAL (this section)**

OTHER _____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
 _____ **TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE:

HEALTH GOALS

Name: _____

Date: _____

Please describe the **top three (3) symptoms/conditions** you seek to improve at our office (**in order of importance**). Please provide a brief timeline or review of the contributing factors as you see it.

Problem #1: _____

Problem #2: _____

Problem #3: _____

MEDICAL CARE HISTORY**PREVENTIVE TESTS***Check box if yes and provide date*

- | | |
|--|-------|
| <input type="checkbox"/> Full Physical Exam | _____ |
| <input type="checkbox"/> Bone Density | _____ |
| <input type="checkbox"/> Colonoscopy | _____ |
| <input type="checkbox"/> Cardiac Stress Test | _____ |
| <input type="checkbox"/> EKG | _____ |
| <input type="checkbox"/> Hemocult (stool test for blood) | _____ |
| <input type="checkbox"/> Mammogram | _____ |
| <input type="checkbox"/> PAP Smear | _____ |
| <input type="checkbox"/> PSA | _____ |
| <input type="checkbox"/> Other _____ | _____ |

DATE**SURGICAL HISTORY***Check box if yes and provide date*

- | | |
|--|-------|
| <input type="checkbox"/> Appendectomy | _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Ovaries removed:
Right / Left / Both | _____ |
| <input type="checkbox"/> Gall Bladder | _____ |
| <input type="checkbox"/> Hernia | _____ |
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | _____ |
| <input type="checkbox"/> Joint Replacement - Knee/Hip | _____ |
| <input type="checkbox"/> Heart Surgery (<i>type</i>) _____ | _____ |
| <input type="checkbox"/> Angioplasty or Stent | _____ |
| <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Other _____ | _____ |

DATE**HOSPITALIZATIONS**

Date	Reason for Hospitalization

SPECIALIST CARE *Please list all physicians that manage your care.*

Physician Name	Medical Specialty	Issue(s) Being Managed

MEDICAL HISTORY

Check appropriate box and provide date of onset

= Past Condition(pc)

= Ongoing Condition(oc)

DISEASES/DIAGNOSIS/CONDITIONS

pc	oc	GASTROINTESTINAL	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gastritis or Peptic Ulcer	_____
<input type="checkbox"/>	<input type="checkbox"/>	GERD (Acid Reflux)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Celiac Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	CARDIOVASCULAR	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia (irregular beat)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	METABOLIC/ENDOCRINE	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia (low blood sugar)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Insulin Resistance or Pre-diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Obesity/Overweight	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism (underactive)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism (overactive)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome (PCOS)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Infertility	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	NEUROLOGIC/PSYCHIATRIC	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	_____
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	_____
<input type="checkbox"/>	<input type="checkbox"/>	Autism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder (Anorexia/Bulimia)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	GENITAL AND URINARY SYSTEMS	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	_____
<input type="checkbox"/>	<input type="checkbox"/>	Interstitial Cystitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urinary Tract Infections	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Yeast Infections	_____
<input type="checkbox"/>	<input type="checkbox"/>	Erectile or Sexual Dysfunction	_____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	MUSCULOSKELETAL/PAIN	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gout	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	INFLAMMATORY/AUTOIMMUNE	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hashimoto's Thyroiditis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Chemical Sensitivities	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	RESPIRATORY DISEASES	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	COPD or Emphysema	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	SKIN DISEASES	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vitiligo	_____
<input type="checkbox"/>	<input type="checkbox"/>	Acne	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

pc	oc	CANCER	date of onset
<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	_____

FEMALE HISTORY

OBSTETRIC HISTORY

(Check box if yes and provide number of times)

- Pregnancies _____ Cesarean _____ Vaginal Deliveries _____
 Miscarriage _____ Abortion _____ Living Children _____
 Postpartum Depression Toxemia Gestational Diabetes Baby over 8 lbs
 Breastfeeding For How Long? _____

MENSTRUAL HISTORY

Age at first period _____ Menses Frequency _____ days Menses Length _____ days

Describe your **current** menstrual cycle Regular Irregular Absent

Details: _____

Last Menstrual Period: _____ Date of Last PAP: _____

History of Abnormal PAP? Yes No If yes, date of abnormal PAP: _____

Current contraception? None Condom Diaphragm IUD Vasectomy Birth Control Pill

Total years of hormonal contraception use? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES (check all that apply)

- Fibrocystic Breasts Endometriosis Fibroids Infertility
 Painful Periods Heavy Periods PMS

Are you in Menopause (no menses in last 12 months)? No Yes (if yes, What age? _____)

If yes, Natural Surgical removal of ovaries

Current use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

Previous use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

Menopausal Symptoms: Check all that apply

- Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness
 Night Sweats sleep problems Postmenopausal bleeding Loss of Control of Urine
 Headaches Palpitations Weight Gain Depression or Anxiety

MALE HISTORY

Have you had a PSA done? No Yes (Date of last PSA? _____)

PSA Level 0-1 2-4 5-10 >10

Check all that apply

- Erectile Dysfunction
 Nocturia (urination at night) How many times per night? _____
 Urgency/Hesitancy/Change in Urinary Stream
 Enlarged Prostate

DIGESTIVE/DIETARY HISTORY

Please describe your typical daily diet by indicating your usual daily servings:

Vegetables: _____	Dairy: _____
Fruits: _____	Potatoes: _____
Beans: _____	Fats/Oil: _____
Nuts/Seeds: _____	Fast Food: _____
Whole Grains: _____	Refined Grains: _____
Animal Protein: _____	Processed Foods: _____

Overall, do you feel that you eat . . . (check all that apply)

- Too Much Too Little Just enough
 Very Healthy A Little Unhealthy Unhealthy

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

If yes, within 30 min after eating after 1-2 hours of eating

Were there years where you took more than 3 courses of antibiotics per year? Yes No

Do you experience frequent yeast infections or toe fungal infections/athlete's foot? Yes No

Do you get sick from strong smells, chemicals or medications easier than most people? Yes No

Are there some foods to which you are allergic, intolerant or just seem to bother you?

Explain: _____

Do you suffer from allergies? Environmental Food

If environmental, are they . . . Seasonal All Year Long

Do you ever find blood in your stool? Yes No

How many bowel movements do you have in a typical day? <1 1 2 3 4 _____

If you answered <1, how often do you have a bowel movement? Every _____ days

Describe your typical bowel movement (check all that apply)

- | | | |
|--|----------------------------------|---|
| <input type="radio"/> Hard | <input type="radio"/> Soft | <input type="radio"/> Alternating diarrhea/constipation |
| <input type="radio"/> Pellet-like | <input type="radio"/> Loose | <input type="radio"/> Mucus in stool |
| <input type="radio"/> Requires straining | <input type="radio"/> Watery | <input type="radio"/> Undigested food in stool |
| <input type="radio"/> Complete | <input type="radio"/> Incomplete | <input type="radio"/> Strange color/odor |

If you experience any digestive issues, when did they begin?

- Last 3-6 months Since childhood
 Last 6-12 months Can't remember
 _____ years ago

Have you ever been referred to a Gastroenterologist? Yes No

Explain: _____

LIFESTYLE INFORMATION

SMOKING

Currently Smoking? Yes No How many years? _____ Packs per day: _____
 Attempts to quit: _____ Using what methods: _____
 Previous Smoking? Yes No How many years? _____ Packs per day: _____
 Quit Date: _____
 2nd Hand smoke exposure? None Low Medium High

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz beer, 1.5 oz liquor)*
 None 1-3 4-6 7-10 >10 ; throughout the week weekends mostly
 Do you frequently (more than 2x/week) take:
 >1 drink per day for females
 >2 drinks per day for males
 Previous alcohol intake? None Mild Moderate High
 Do you ever feel guilty about your alcohol consumption? Yes No
 Do you notice a tolerance to alcohol (you can "hold" more than others)? Yes No
 Do you notice you 'feel' your alcohol at very low amounts? Yes No

OTHER SUBSTANCES

Caffeine intake
 Cups per day: Coffee: _____ Tea: _____ (Herbal Non-Herbal)
 Caffeinated or Diet Beverages per day None 1 2 3 ≥ 4
 List favorite type (e.g. Diet Coke, Pepsi, Red Bull, Monster, etc) _____
 Do you often take caffeine to avoid fatigue? Yes No

EXERCISE

Current Exercise Program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency/week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Yoga/Pilates			
Sports/Leisure Activities <i>(golf, tennis, rollerblading, etc)</i>			

Do you feel unusually fatigued after exercise? Yes No
 If yes, please describe: _____
 Do you usually sweat when exercising? Yes No

LIFESTYLE INFORMATION

STRESS/COPING

Have you ever sought counseling? Yes No

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can manage the stress in your life? Yes No

Do you feel you make unhealthy choices due to high stress? Yes No

Daily Stressors: (Rate on a scale of 1-10 1 = lowest, 10=highest)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? Yes No

Check all that apply: Yoga Meditation Breathing Tai Chi Prayer Other _____

SLEEP/REST

How likely are you to doze off or fall asleep in the following situations using the scale below?

0 = Would never doze

2 = Moderate chance of dozing

1 = Slight chance of dozing

3 = High chance of dozing

Sitting and reading	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting inactive in a public place (ex, a theater or meeting)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting and talking to someone	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting quietly after a lunch without alcohol	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
In a car, while stopped for a few minutes in traffic	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
As a passenger in a car for an hour without a break	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

Average number of hours you sleep per night? > 10 8-10 6-8 < 6

Do you have trouble falling asleep at night? Yes No

If yes, how long does it usually take to fall sleep? _____

Do you have trouble staying asleep at night? Yes No

If yes, how long are you awake throughout the night? _____

How many times do you awaken throughout the night? _____

Please list any sleep aids (prescription or natural) or other methods tried: _____

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Educate yourself on your condition	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Significantly modify your diet	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Modify your lifestyle (work demands, sleep, etc)	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Practice a relaxation technique	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Take several nutritional supplements each day	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Engage in regular exercise	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Have periodic lab tests to assess your progress	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

Comments _____

GENETIC RISK ANALYSIS

Please place age at diagnosis where appropriate. For multiple siblings/children, place multiple checks age.

	Mother	Father	Brother(s)	Sister(s)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt(s)	Uncle(s)
Age (if still alive)											
Age at death											
Colon Cancer											
Breast Cancer											
Other Cancers - List Type _____											
Heart Disease											
Stroke											
Hypertension											
Obesity/Overweight											
Diabetes											
High Cholesterol											
Arthritis (<60 years old)											
Multiple Sclerosis											
Rheumatoid Arthritis / Lupus / Psoriasis											
Ulcerative Colitis / Crohn's Disease											
Irritable Bowel Syndrome (IBS)											
Celiac Disease											
Asthma / Chronic Bronchitis											
Eczema/Hives											
Food Allergies or Sensitivities											
Environmental Sensitivities											
Multiple Chemical Sensitivities											
Dementia or Parkinson's											
Substance Abuse (alcoholism, drugs)											
Depression											
Anxiety											
ADHD											
Autism											
Thyroid Disorders											
Other _____											
Other _____											
Other _____											

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (Last 10 years)

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement	Strength	Dosing Schedule	Start Date (month/year)	Brand of Supplement

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

- I accept that SevaMed Institute, P.A., is a unique education-based medical practice requiring me to be a full partner in my healthcare by maintaining an active LivingWellnessUniversity.com yearly membership. I understand the following:
 - The education offered at LivingWellnessUniversity.com is a comprehensive tool developed by Dr. Saxena that facilitates better understanding of the key concepts regarding health promotion and disease management of the most common primary care conditions that may affect me or my family members.
 - LWU provides the key medical information that allows me to better understand my condition and associated treatment options so that I can best participate in the shared decision making required of a therapeutic doctor-patient relationship.
 - LWU allows SevaMed Institute, P.A. to provide an above average amount of information including functional, integrative and conventional medicine perspectives that is unable to be achieved during the typical insurance-based doctor's visit time period.
 - Dr. Saxena specializes in identifying and correcting underlying causes of illness and fostering health promotion in addition to chronic disease management. Experience shows that patients who understand their condition(s) have better outcomes because they more fully participate in the lifestyle change recommendations that are essential to better health status.
 - If you choose to opt out of LWU or fail to maintain your active LWU membership, SevaMed Institute, P.A. would be unable to provide the optimal education-based medical care and partnership we require and will result in a recommendation to select a practice which better matches your healthcare philosophy.
- Payment is due at the time of service. Non-covered lab fees must be paid to the clinic at the time your provider orders them as the clinic will be incurring lab charges on your behalf. We accept Cash, Check, MasterCard and Visa. Any unpaid balance after 120 days from the date of service is the responsibility of the patient/guarantor.
- All balances are due prior to your appointment. Any unpaid balance is subject to appointment cancellation.
- It is your responsibility to notify SevaMed Institute of any changes to your insurance coverage and personal information, immediately to avoid billing issues.
- Appointment cancellations must be made more than one business day in advance of all routine, scheduled appointments to avoid penalty. Any routine appointments that are cancelled or missed with less than one business day will automatically be charged a \$25 cancellation fee for 20 minute appointments and \$50 for 40 minute appointments.
- If you are more than 15 minutes late for your appointment, you may be asked to reschedule. In this event, the appropriate cancellation fee will be applied.
- After hours access: If you have an emergency, please call 911. If you have an urgent medical matter, please call our main office number and follow the recorded directions. Be sure to leave your name, phone number and reason for your call. As this service is strictly for urgent matters, please do not leave messages for prescription refills, appointments, referrals or other non-urgent matters. Please call during normal business hours to address those non-urgent situations.

- Refill requests: All local pharmacy refill requests require at least 3 business days notice. Allow 1-2 weeks notice for mail-order prescriptions, or more based on your mail-order pharmacy guidelines.
- All requests for medical records beyond a single office visit will be assessed a fee of \$1 per page for the first 25 pages and \$.25 per page thereafter.
- All evaluation forms required to be completed by a health care provider must be done during an office visit. Other forms may require a \$25 or more completion fee based upon professional time spent.
- All diagnostic test results require doctor review/interpretation before copies will be provided to you. SevaMed requires an office visit to receive interpretation and treatment guidance for all abnormal results. Normal lab results can be mailed upon request. Medical records fees may apply for a large volume request.
- Any prescribed medical foods, nutrient therapy or hormonal creams must only be taken under medical supervision and as such, must be dispensed from an approved compounding pharmacy or directly from SevaMed Institute.
- Healthcare is not an exact science and, therefore, I acknowledge that **no** guarantees are made to me as to the results of the examinations, tests, diagnoses or treatment by SevaMed Institute or any representative thereof.
- Any prescription medications prescribed by another physician should **not** be discontinued without the consent of the prescribing clinician.
- If you do not have a Primary Care designation with Dr. Saxena, she highly recommends that you share your care plan and treatment plan with your primary care physician and medical specialists for safety purposes.
- I understand office terms and conditions may be updated periodically and I will be responsible and adhere to the most current version which will be posted on www.sevamedinstitute.com.

I fully understand and accept the above listed policies, and I do hereby voluntarily consent to evaluation and care with SevaMed Institute including physical exam and any mutually agreed upon diagnostic testing and treatment recommendations.

Patient/Guardian Signature

Date

Printed Name

Patient Date of Birth



New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, SevaMed Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment.

I understand a Notice of Privacy Practices is available for my review. It provides a complete description of information use and disclosure (a copy can be provided upon my request). I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations.

I understand that SevaMed Institute is not required to agree to the restrictions requested below. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SevaMed Institute reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulation. Should SevaMed Institute change their notice, they will send a copy of any revised notice to the address I have provided, (US mail or e-mail).

I wish to have the following restrictions for the use and disclosure of my health information:

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

Patient/Guardian Signature

Date

Patient Name



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, give permission to SevaMed Institute to release any information, verbally or written, on my behalf to the following persons.

PLEASE PRINT

Name: _____

Phone: () _____ Relationship to Patient: _____

Name: _____

Phone: () _____ Relationship to Patient: _____

Name: _____

Phone: () _____ Relationship to Patient: _____

This notice will expire upon written notice as provided by patient to SevaMed Institute.

Patient/Guardian Signature

Date

Printed Patient's Name

Witness Signature

Date

Appeals Department

Member Authorization Form for a Designated Representative to Appeal a Determination and Assignment of Benefits

Date: _____

Member Name: _____

Member ID#: _____

I hereby authorize Lutz Surgical Partners to appeal my Insurance's determination concerning dates of service on my behalf, as my Designated Representative, and as part of the appeal, I hereby authorize my Insurance in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. I hereby authorize my insurance carrier to direct payments of medical benefits to:

Lutz Surgical Partners LLC
PO Box 2667
Lutz, FL 33549
FEDERAL TAX ID #20-8072979

Signature of Member or Legal Guardian/ Representative

Signature of Witness

Name of Witness

Why is SevaMed Institute becoming an 'education-based' practice?

- In medicine, it is fairly typical for patients to be 'secondary' decision makers in their care. Once a physician feels that they've identified the problem, they order testing, write prescriptions and schedule procedures that they feel are necessary with patient 'consent'. We believe that patients have many critical pieces of information about their body that would majorly impact the decision making process. However, without proper education of the health condition, patients might not be able to process their thoughts, participate in a productive 2-way conversation with their doctor and create the best plan for them.

This is where education comes in. Living Wellness University (LWU) has been developed from Dr. Saxena's years of experience and listening to patients and their most common concerns and questions. She is very confident that this is the way medicine will be practiced in the future and is committed to revolutionizing using the most effective and productive partnerships between doctor and patient seen at any doctor's office.

What does it mean to be an 'education-based' practice?

- An 'education-based' practice finally places the patient at the center of his/her care. We want you to understand important details about your conditions so you can sit with us side-by-side in the decision making process. Living Wellness University is how we can help you.

As part of your care at SevaMed Institute, you will be required to register with Living Wellness University so you can view certain lectures, doing your part in bringing a solid foundation of knowledge about the assigned topic(s) to your appointment. For example, if your most recent blood work shows a newly diagnosed diabetes problem, you may be assigned lectures related to diabetes, diabetes medications, heart disease and/or lifestyle solutions related to lowering blood sugar naturally. Knowing this information in advance of your appointment, you will best contribute towards the most productive, intelligent and respectful recommendations for you.

We will be educating and transitioning our current patients on this change and are excited to have all interested patients join us in this new partnership-based approach. Although we will begin recommending LWU lectures through the rest of the year, we are providing time for current patients to process our 'change' and will formally require patients to register with Living LWU as of January 1, 2012 if they are on board with us. All new patients will be required to participate in the 'education-based' approach upon registration with SevaMed Institute.

How is LWU different than WebMD or other medical information internet sites?

- As Specialists in Functional and Integrative medicine, all of the educational material at Living Wellness University provided by Dr. Saxena is based on Functional and Integrative medicine perspectives and principles that patients seek at SevaMed Institute. These innovative, 'less medication' focused approaches are not found on traditional medical information sites. Additionally, the educational material on Living Wellness University is easy to understand, provides the conventional, functional and Integrative perspective all in one place. The audio-visual lectures delve much deeper into each health topic with the intent of answering your questions and reducing anxiety, not creating more questions and increasing fears like most other websites.

What should I expect in my visits?

- When patients come to their appointments with a strong understanding of their issues, the visit is more collaborative and medical decisions are made in an informed, educated manner. Patients also enjoy the ability to create well-prepared questions and concerns, and always have the ability to go above and beyond with their education at home, not being limited by the constraints of the appointment time, insurance and finances related to multiple doctors' visits.

At your appointment, you can expect an enhanced, deeper discussion with your provider. You will no longer feel that you have to make on-the-spot decisions with not-enough information, later festering about whether you made the right choice or not. As we know, people are less committed to following through on their decisions if they are not confident they are the best ones. This leaves both patient and physician in more risky situations. We are excited to strengthen this common sense need for comprehensive, easy-to-access healthcare information to you in the convenience of your own home.

How is my care managed?

- Your specific, individualized care plan is organized and led by Dr. Saxena and then put into action by the appropriate 'specialists' on our team. Every member of the SevaMed Team has their own area of passion & expertise, and the timing of when you see them is determined during our weekly team meetings when we discuss & coordinate our patients' personalized care plans. So rather than being cared for by one doctor, your care is carefully orchestrated among a team of experts, each with something unique to add to your experience.

How do I register for Living Wellness University?

- Registration is simple. Visit LivingWellnessUniversity.com. Follow the prompts to purchase securely online. Only one membership per household is needed. Thus, all the members of your family that reside together will benefit with only one registration.

What if I am unable to afford the Living Wellness University registration fees?

- We have priced this comprehensive, online medical information tool in a way that allows the majority of our patients to participate with minimal yearly expense. However, we understand that some families might have significant hardships at this time and considerations will be made with documented proof of financial hardship. We will use a sliding scale fee system and/or payment plans to help facilitate access to this required information. Please call the office if you believe you qualify for more direction.

What if I don't have a computer or internet access?

- For these patients, we will have DVD versions of the lectures available to sign out at the office. This will ensure your registration still achieves the goal of educating you on your healthcare conditions.

What happens if I don't register or cancel my registration?

- We are deeply committed to changing the way we practice medicine for many reasons. First, we've experienced how well it works – we know that better educated patients, get healthier. We've already received such positive feedback regarding our education-based methods and want the involvement of our entire patient community. Finally, we don't believe the current model works well for us either – we want you to be an educated partner in your care so that we can optimize our visits with you and feel good about the decisions we make together. Living Wellness University truly helps both patient and provider to work closer together for the best results for you.

We also understand that this 'education-based' approach is not for everyone. If you choose to not register or cancel your registration, we strongly recommend that you seek the services of another physician or practice that is a better fit for your healthcare philosophy and needs.