Diabetes and Wellness Clinic
PATIENT INFORMATION

Date: ____/____/_____

First Name MI Last Name Maiden

Street Address

City State Zip Code

Home Phone Cell

Email

Date of Birth: _____ __ Female __ Male

Patient Marital Status: __ Single __ Married __ Divorced __ Widowed

Spouse's Name *(if applicable)*:

Patient Status: __Employed __Not Employed __ Full-time Student __ Part-time Student

Patient's Employer:

Employer Address Phone

Emergency Contact Information:

(#1) Emergency Contact Name Phone Relationship

(#2) Emergency Contact Name Phone Relationship

How did you hear about us?

What is the main reason for your visit today:

Preferred Pharmacy_____

Primary Insurance_____

Secondary Insurance_____

Medication History: *(please list medication name, dose taken, frequency and what you take that medication for)*

Allergies: *(please list all allergies to medications and reactions associated)*

Primary Care Provider: *(provide name, facility, specialty and phone number)*

Past Medical Conditions/History: *(including surgeries and dates)*

Signature of Patient or Authorized Representative Date

Print Name of Patient Print Name of Authorized Representative

Fundamental Wellness Intake New Patient Paperwork

Past Medical History

-In functional medicine we want to know about your ENTIRE Life. Some of these questions may seem irrelevant to you, but it is important in understanding what has led to your current symptoms. We like to know dates if you know them, if you aren't sure, do your best to pick a year in the ballpark. Some entries may require additional space, please attach a separate sheet of paper if necessary and use the title of the section you are sharing information with. This will help maximize our time together so we can gain a better understanding of your current ailments.

Birth

-Vaginal/C-section Term/Preterm Complications at birth_____

-Mother illness during pregnancy _____

Feeding History

-Breast/Bottle Fed _____how long if Breastfed _____age formula feeding

_____age introduced Cows Milk _____age introduced wheat

Illness/Symptom History

Birth to age 5 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

School age 6-12 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Adolescents age 13-19 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Early Adulthood age 20-30 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Adulthood age 31-40 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Middle Adulthood age 41-60 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Older adulthood ages 61-75 (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Advanced Adulthood ages 76+ (list in order, with years if possible, if you are able to remember, ear infections, surgeries, or if any significant symptoms, ie-stomach pain, sleep problems etc.)

Traumatic Events/Experiences (any event/experience in your life you found difficult, from a move, divorce, job change to physical, emotional, or sexual abuse, provide as much information as you feel comfortable in this space)

Any identifiable triggering events: (triggering events are identified as something that happened in your life when things "started to go down hill." It could be associated with one of your traumatic events or a surgery or illness) Please list the event and what symptoms began with that event.

Chronic Conditions (medical conditions you are currently diagnosed with that you take medicine for or have taken medicine for in the past)

Medications

Please list Medications/Supplements you currently take along with doses and frequency (*please bring all medication/supplement bottles with you to your appointment)

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

Medications you have taken in the past that you DID NOT tolerate or did not find helpful, please write "N/A" if this does not apply to you.

Allergies to Medications (please list what you are allergic to and what happens to you)

Known food intolerances:

Current Illness (Please describe what symptoms you are having and why you are seeking care):

Family History

-Please list all medical conditions the following family members have-if any- if they are living or deceased- and what age they are now like the following examples

Mother- 66 -Living, history of a pulmonary embolism, gallbladder removed, arthritis

**Father-64-Deceased Chronic Myelogenous Leukemia, Atrial fibrillation, High blood pressure*

Mother-

Father-

Siblings (please list order of birth ie. Brother, sister)

Children (please list order of birth ie. Daughter, son)

Maternal Grandmother-

Maternal Grandfather-

Paternal Grandmother-

Paternal Grandfather-

Social History

Describe your childhood.

Who raised you?

Occupation:

Living arrangements (please circle)- House/Apartment Rent/Own

Does anyone else other than immediate family live with you? (please circle) Yes/No

*if yes, please explain here:

Do you smoke cigarettes/vape/chew tobacco? (please circle) Yes/No

*if yes, please state how much: _____

Do you drink alcohol? (please circle) Yes/No

*if yes, please state how much/how often: _____

*Do you need an "eye opener" to function? Yes/No

*Do you get shaky, sweaty, or irritable if you go too long without a drink? Yes/No

*Have you ever experienced seizures from withdrawal? Yes/No

Do you currently, or have you ever used illicit drugs including marijuana? Yes/No

*if yes, please list below

	Substance of Choice	Last Use
1)	_____	_____
2)	_____	_____
3)	_____	_____

Lifestyle

Food

If you were to give your current diet (food you eat) a letter grade, what would it be?

A B C D F

Why?

How much water do you drink? (ounces)

Sleep

How many hours of sleep do you get?

If you have sleep difficulties, please share the types of difficulties?

Stress

Describe any stressors?

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
0 – *Never or almost never* have the symptom
1 – *Occasionally* have it, effect is ***not severe***
2 – *Occasionally* have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

Diabetes and Wellness Clinic LLC and D & W Integrative Care LLC

Registration and Agreements

AUTHORIZATION FOR MEDICAL, HEALTH AND/OR NUTRITION SERVICES:

Pursuant to this Client Registration Agreement, I/we authorize Diabetes and Wellness Clinic LLC and/or D & W Integrative Care LLC to administer such medical, health care and/or nutrition services, treatments and procedures for me or my family member as deemed appropriate and necessary under the applicable circumstances. I/we understand that he will prescribe an integrative program that may include conventional health care, nutritional therapies, functional medicine and other elements of integrative medicine. I/we understand that if any explanations as to benefits and/or risks and dangers of the prescribed treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. I/we understand that there are no warranties, representations or assurances of successful outcomes for me or my family members. Nevertheless, I/we desire to pursue integrative medical treatment or nutrition services for myself or my family members after reviewing the information herein and receiving answers to any questions related to this Agreement. As a patient or family member seeking medical, health care and/or nutrition services, I/we understand that I/we are ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services). I/we will report to Diabetes and Wellness and/or D & W Integrative Care any matters arising out of treatments or services and schedule an appointment to conduct appropriate follow-up. I/we will promptly seek medical attention from Diabetes and Wellness and/or D & W Integrative Care or another medical facility if any of us experience any unanticipated effects associated with treatments and services or if the treated condition worsens. If a medical emergency arises, I/we will call 911 or visit the nearest hospital emergency room. I/we understand that Diabetes and Wellness and/or D & W Integrative Care does have a provider on-call at all times if needed urgently.

TELEPHONE AND EMAIL CONSULTATION POLICY :

Diabetes and Wellness and/or D & W Integrative Care checks telephone and email messages during business hours and responds to them on a regular basis throughout the week. Please leave non-urgent messages only, and please allow up to 2 working days for response. If your questions and/or concerns are more complex, a follow-up appointment will be requested. If you are experiencing a medical emergency, please call 911 or go directly to an emergency room. In general, Diabetes and Wellness and/or D & W Integrative Care does not follow-up with telephone messages and/or emails that occur after hours, on weekends or holidays. By sending an email, I/we acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I/we will not use email communications to deal with emergencies or other time sensitive issues. I/we also understand and agree that email communications (outside of the secure patient portal) may not be secure and the confidentiality of emails cannot be assured or guaranteed, but agree that this is my/our risk with respect to all email communications. Diabetes and Wellness and/or D & W Integrative Care may keep copies of email communications, and such messages may be included in the health record.

HEALTH INFORMATION RELEASE AUTHORIZATION AND PRIVACY PRACTICES :

Diabetes and Wellness and/or D & W Integrative Care is permitted by applicable federal and state privacy laws to use and disclose my/our protected health information (PHI) for treatment, payment and health care operations and for other purposes as required or permitted by law. Our Notice of Privacy Practices, as it may be amended from time to time ("Notice of Privacy Practices"), is available on the website, by email upon request or in person at the office. I/we authorize Diabetes and Wellness and/or D & W Integrative Care to release my/our medical records in connection with treatment, payment for services and its health care operations and as provided in the Notice, which is incorporated into this Agreement by reference. I/we understand that the Notice may be modified or amended on the basis described in the Notice. I/we also authorize any physician or health care provider to release their protected health information records to Diabetes and Wellness and/or D & W Integrative Care. This authorization extends to my protected health information records, if applicable.

COMPLAINTS, COMMENTS AND QUESTIONS :

Diabetes and Wellness and/or D & W Integrative Care is committed to providing quality care and resolving favorably any complaint, problem, question or unsatisfactory experience that might occur in connection with medical or nutritional services. It the policy of Diabetes and Wellness and/or D & W Integrative Care that (i) if any person has a complaint or problem or unsatisfactory or negative experience related to our business, services or products, such person must bring the matter to our attention privately, by email, phone or in person; and (ii) he will investigate any such matter and attempt in good faith, without any retaliation, to reasonably resolve the matter. By registering, I/we agree to comply fully with this policy. This is my/our sole and exclusive remedy in connection with any complaint or problem or unsatisfactory or negative experience that I/we may have with Diabetes and Wellness and/or D & W Integrative Care, services or products (other than remedies available in a court of law or pursuant to arbitration). I/we further agree not to publish, post, transmit, disclose or distribute (directly or indirectly), in or on any publicly available or accessible forum, newspaper, magazine, electronic publication, blog, website, online users group or similar device, document or medium, any negative, false or disparaging comment, belief, opinion, experience or information (or that could reasonably be so construed), without prior written consent. I/we acknowledge and agree that these terms are reasonable and that any breach or violation of this paragraph will cause significant damage and expense that would be impossible or highly impractical to quantify and establish. Consequently, I/we agree that upon each breach or violation of this paragraph, I/we will be obligated, jointly or severally, to pay liquidated damages in the amount of $200.00 per day per violation until the breach or violation has been cured to satisfaction.

DURATION OF AGREEMENT, REVOCATIONS OF AUTHORIZATIONS AND AMENDMENTS :

I/we may revoke the medical records release authorization in writing at any time and Diabetes and Wellness and/or D & W Integrative Care will attempt to accommodate all reasonable requests. However, I understand that in some circumstances related to treatment, payment or

health care operations Diabetes and Wellness and/or D & W Integrative Care may not be able to accommodate such requests. I further agree that, in no event, will any revocation of a prior authorization affects any of my other obligations in this Agreement. The rights and obligations of the parties herein shall be fully applicable, and the respective rights and obligations of the parties shall survive expiration, cancellation or termination of this Agreement for any reason. I/we also certify that my family or I am enrolled in this practice to receive medical and health care and for no other purpose. This Agreement and the Notice, along with any agreement to arbitrate, reflects the entire and exclusive agreement between us and supersedes any prior or other contemporaneous agreement. This Agreement may only be amended by a written document signed by Diabetes and Wellness and/or D & W Integrative Care and the registering patient or patient's legal advocate.

CONTROLLED SUBSTANCES:

I understand that treatment by the providers at Diabetes and Wellness and/or D & W Integrative Care may include medications for pain management, insomnia, anxiety, attention disorders and others. I understand that some of the medications that may be prescribed carry the risk of addiction. Since some medications do carry this risk, special care must be taken by the provider and the patient. For controlled substances, visits will be required every 1-6 months depending on the substance and based on provider discretion. This is required to document stability on the medication, the effectiveness of the medication, and side effects of the medication.
Here is a list of some of the common medications, although not all-inclusive, which may require more frequent visits: hydrocodone, lortab, norco, vicodin, oxycodone, percocet, oxycontin, methadone, nucynta, clonazepam, alprazolam, lorazepam, ambien, lunesta, sonata, adderall, evekeo, concerta, vyvanse. If you would like to know about a specific medication, please inquire at the office.

I understand that
1. Random urine drug screens will be obtained.
2. You may be referred to a pain management, psychiatry, or psychiatry at provider discretion.
3. When you need a refill, schedule an appointment.
4. Controlled substances will be taken only as prescribed. If you feel you need a dose or frequency change, and appointment is required.
5. There will be no early refills or replacements of lost prescriptions or medications. Federal law prohibits the writing of more than a certain number of pills per drug at a time. Providers and pharmacists are held accountable.
6. It is recommended that prescriptions be locked up when not in your possession. It is important they are kept away from children at all times.
7. There will be no attempts to alter prescriptions, sell medications, or obtain other controlled substances from any source other than Diabetes and Wellness and/or D & W Integrative Care (unless agreed upon by patient and provider) or treatment will end immediately.
8. Medications are part of the overall treatment plan and when asked, the patient should comply with non-medicine recommendations for treatment (For example; physical therapy).
9. When there are no alternative to manage my condition, I/we will make regular attempts at reducing the dosage and/or developing an alternative approach to handle the medical condition.

INSURANCE RESPONSIBILITY AND CLAIMS MANAGEMENT:

I/we acknowledge that Diabetes and Wellness and/or D & W Integrative Care strongly urges that all patients maintain health insurance coverage. It is my/our responsibility to know my/our plan benefits and to obtain insurance advice from my/our own licensed insurance agent, broker or human resource professional. Given the uncertainty that pervades insurance decisions, I/we agree that Diabetes and Wellness and/or D & W Integrative Care is not responsible for any information related to my/ our insurance that turns out to be incorrect. I/we agree that Diabetes and Wellness and/or D & W Integrative Care is not obligated to take action on my/our behalf against an insurance company related to any insurance claim or payment. I/we will be responsible for all charges and fees incurred for treatments or services rendered, even if my/our insurance company determines that any services are noncovered or excluded. I/we understand that insurance reimbursement may not be available for some services. My/our insurer may not pay for office visits, telephone consultations or emails including but not limited to circumstances where the focus of the consultation is on prevention, education, wellness, nutrition advice, herbal medicine, etc. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed.

FINANCIAL AGREEMENT

1. Diabetes and Wellness and/or D & W Integrative Care files insurance claims for patients as a courtesy, but we accept no responsibility for doing so. Regardless of your insurance, you have FULL RESPONSIBILITY for payment of your bill. It is also your responsibility to know and understand your in or out-of-network status, as well as copays, deductibles, co-insurance that may apply.
2. Co-payments are due at time of service. Our contractual agreement with your insurance carrier prevents us from waiving your required copay, deductible, or coinsurance.
3. The "patient balance" is due within 15 days of receipt of your invoice unless other arrangements are made. We will collect outstanding balances prior to each visit.
4. If you have no insurance, your fee for service will depend on the level of your visit. Please inquire for details or the pay at time of service discount.
5. We accept cash, credit/debit, and check at this time.
6. A $35.00 service charge will be assessed for returned checks.
7. Laboratory; if you have blood drawn you MAY be billed separately by the lab that conducts the tests. A laboratory processing fee may apply in certain instances.
8. If you can not pay in-full at the time of your visit, please make arrangements prior to your visit. Payment plans are determined by the amount of the owed balance, and are subject to approval by Diabetes and Wellness and/or D & W Integrative Care
9. Call to collect any billing errors promptly. If you ignore billing statements or phone calls, we assume that you do not intend to pay for the medical services that were provided in good faith and your account will be forwarded to a collection agency.
10. Personal injury - we will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to be sought by you for reimbursement. If you have medical payment coverage with the automobile insurance carrier, you must provide claim and contact information for that insurance carrier at the time of visit.
11. Work-related injuries - Prior authorization for care is the responsibility of the patient. If prior

authorization is not obtained, you are responsible for full payment at the time of service. If your worker's compensation carrier has not paid your account within 60 days of the date of service, the owed balance will become the responsibility of the patient.

12. I/we understand that my/our appointment time with Diabetes and Wellness and/or D & W Integrative Care is reserved exclusively for my/our care for the duration of all scheduled visits. I/we understand that I/ we are expected to keep all appointments as scheduled in order to ensure maximum progress in connection with treatment and care. If I/we need to cancel or reschedule an appointment, I/we will call during business hours at least two business days in advance. No charge will apply in this situation. As an illustration, if an appointment is on a Monday, canceling during business hours on the prior Thursday provides two business days' notice. I/we understand that if I/we cancel an appointment during business hours only one business day prior to the scheduled visit, or if I/we fail to show or cancel on the day of the appointment, I/we will be charged a fee of $35.

I have read and understand the above document.

Signature:_____

Date signed:_____