Henry Community Health

Dear Patient,

Welcome to Integrative Well-being! We look forward to partnering in your wellness by improving or maintaining your health. Below is the description of our approach to helping you.

The key to functional medicine is treating each person as an individual and getting to the root cause of the health problems. That process generally entails a detailed conversation about your current state of health, health history, family history, diet, lifestyle habits and any physical exams that are indicated. After this complete medical history is obtained, we can discuss potential approaches and recommended laboratory workups. The first visit is primarily an information gathering and sharing session.

At this first visit, we may make some simple recommendations, but most advice will be deferred until after lab and physical exam results are in and there has been time to thoughtfully consider your case.

The next visit will be scheduled to allow enough time for lab test results to return to our office. Due to the comprehensive nature of some of these tests, results will need to be discussed at an office visit. This discussion will include what may be causing your health problems arid what supplementation (vitamin, minerals, herbs), diets, and lifestyle changes may be needed, as well as any medication that may be appropriate tbr your care. If the results are not in our office a week before this appointment, the follow-up appointment will need to be rescheduled.

After these two visits, further follow up visits will be scheduled in approximately 4-16 weeks later to evaluate progress and make adjustments to your program. How often you need to have office visits will depend on why you are being treated and what treatment your program requires.

If you have any further questions after reading this letter, please call our office. We will be happy to assist you. Please be sure to complete all forms and return them to our office. At that time, your first appointment will be scheduled.

In Health,

Integrative Well-being Staff

Henry Community Health

Integrative Well Being

The practice of Integrative Medicine requires the understanding of clients as a whole: Mind, body and spirit. Please take the time to fill out this intake form as completely as possible. This form will provide a foundation for your experience at this office, as it will help to stimulate areas that may need special attention during your visit.

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Referral Source: Physician: Dr. _____

Primary Care Physician: _____

Goals: Please list the reasons you came to Integrative Well Being.

_____

_____

_____

I firmly believe that our lifestyles affect our overall wellbeing. After completely reviewing your history and evaluating your health status, I will likely be able to develop a plan to improve your health. It is fairly predictable that this plan will involve a change in your current lifestyle. (afterall, none of us have a perfect lifestyle) Recognizing that it can be difficult sometimes to make changes in our lives, please rate how willing you will be to make changes to your current lifestyle (0 not likely at all-10 yes, definitely likely to make changes):

0 1 2 3 4 5 6 7 8 9 10

Past Medical History: Check all that apply and fill in any that is not listed at the end.

__ Allergies
__ Alzheimer's
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Bleeding Disorder
__ Blood Clot (s)
__ Breast Disease
__ Diabetes
__ Diarrhea
__ Diverticulitis
__ Eczema
__ Emphysema
__ Endometriosis
__ Fibromyalgia
__ Gout
__ Heart Disease
__ Kidney Disease
__ Low Testosterone
__ Menopause
__ Migraines
__ Multiple Sclerosis
__ Osteoporosis
__ Panic Disorder
__ Prostate Enlargement
__ Reflux (GERD)

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Past Medical History continued:

__ Broken Bone (s)
__ Cancer- Type:_____
__ Chronic Fatigue
__ Chronic Pain: Where:_____
__ Chronic Sinusitis
__ Depression
__ Hepatitis
__ High Blood Pressure
__ High Cholesterol
__ Hypothyroidism
__ Impotence
__ Irritable Bowels
__ Seizures
__ Stroke
__ Urinary Tract Infection
__ _____
__ _____
__ _____

Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

__ Appendix _____
__ Gall Bladder _____
__ Tonsils _____
__ Sinus Surgery ____
__ Tubes in Ears ____
__ Hysterectomy ____
Check One: __ Total __ Partial
__ Tubal Ligation _____
__ Cardiac Bypass _____
__ Catheterization _____
__ Spinal Fusion _____
__ Joint Replacement ___
Which Joint: _____
__ _____
__ _____
__ _____
__ _____
__ _____
__ _____

Review of Current Symptoms: Please check any symptoms or concerns you have in the last several months.

Constitutional
__ Good general health
__ Recent weight change
__ Headaches
__ Fever
Ear/Nose/Throat
__ Hearing loss or ringing
__ Earaches or drainage
__ Sinus problems
__ Nosebleeds
__ Bad breath or bad taste
__Sore throat or voice change
__ Swollen glands in neck
Eyes
__ Eye disease or injury
__ Wear glasses/contacts
__ Glaucoma
__ Double/blurred vision
Cardiovascular
__ Chest Pain or pressure
__ Palpitations
__ Shortness of breath lying flat
__ Swelling of extremities
Respiratory
__ Chronic or frequent cough
__ Shortness of breath
__Asthma or wheezing

Gastrointestinal
__ Loss of appetite
__ Nausea or vomiting
__ Diarrhea
__ Painful bowel movements
__ Constipation
__ Rectal Bleeding
__ Abdominal pain
Hematology
__ Bleeding or bruising
__ Anemia
__ Past transfusion
Genitourinary
__ Frequent urination
__ Painful urination
__ Blood in urine
__ Change in force of urine
__ Incontinence
__ Kidney stones
Male-testicle pain
__ Female-irregular menses
Neurological
__ Frequent headaches
__ Light-headed/dizzy
__ Convulsions
__ Numbness/tingling
__Tremors
__Head Injury

Musculoskeletal
__ Joint pain
__ Joint stiffness/swelling
__ Weak muscles or joints
__ Muscle pain or cramps
__ Back Pain
__ Difficulty in walking
Skin/Breast
__ Cold hands or feet
__ Hives
__ Rash or itching
__ Hair loss
__ Varicose veins
__ Breast pain
__ Breast lump
Psychiatric
__ Memory loss/confusion
__ Nervousness/Anxiety
__ Depression/Mania
__Addictive behavior
Endocrine
__Excessive thirst/urination
__Sugar cravings/Salt cravings
__Hot/cold intolerance
__Poor sex drive
__ Dry skin

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Review of Current Symptoms continued:

Energy
__ Forgetful
__ Poor Concentration
__Fatigue - Worse time of the day: _____

Sleep
__ Problems falling asleep
__ Problems staying asleep
__ Snore
__ Restless legs
__Night sweats

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member (s) in the space provided):

__ Alcoholism _____
__ Allergies _____
__ Alzheimer's _____
__ Anemia _____
__ Asthma _____
__ Birth Defect _____
__ Bleeding Disorder _____
__ Cancer:
Member/Type:_____
Member/Type:_____
Member/Type:_____
__ Depression _____
__ Diabetes _____
__ Epilepsy _____
__Heart Disease _____
__ High Blood Pressure _____
__ High Cholesterol _____
__ Kidney Disease _____
__ Stroke _____
__ Other _____
__ Other _____
__ Other _____

Allergies:
Are you aware of any drug allergies? ___ Yes ____ No
If Yes, please list the drugs and the reaction you had: _____

_____

_____

Environmental allergies?

_____

_____

Food allergies?

_____

_____

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Social History:

Who lives at home with you? _____

_____

Occupation. Please list what you do, approximately how many hours per week and your level of satisfaction

_____

_____

Has this or any job put you around strong chemicals or smoke? ____ Yes ____No

Tobacco: ___ Yes ___ No If yes, how many per day: _____ How many years: _____
Currently Smoking: ___Yes ___ No If quit, how long ago: _____
Smoke exposure at home: ___ Yes ___No
Alcohol: ___Yes ___ No If yes, how many drinks per week: _____ How many years _____

Drug use (state which drug and if currently using): _____

Medications: Please attach a separate list if need extra space.

Name	Dose	How Often? (if as needed, state average use)

Supplements: Please be as specific as possible. In addition to listing, please bring all supplements to your appointment.

What is it	Manufacturer	Dosage	How Many Per Day	Why You Take It

Stress: Stress and the management of stress is very important to your overall health.

Describe the symptoms that you feel when you are under stress:

_____

Describe activities or techniques you use to relieve stress:

_____

Spiritual Life: Having an active spiritual or religious life is an important part of your overall health. Describe your current spiritual/religious practice (Please provide details as to how often and what you do. For example, do you attend church or other ceremony? Any small group study?:

_____

_____

_____

Previous Complimentary Experiences:

___ Acupuncture ___ Healing Touch ___ Massage ___ Reiki

___ Biofeedback ___Homeopathy ___Meditation ___Psychological Counseling

___Chiropractic ___Hypnotherapy ___Naturopathy ___Yoga

___Guided imagery ___ Iridology ___ Reflexology ___Other (please state)

Additional Dietary Information: Please pr vide honest answers to these questions based on a typical day.

Cups of regular coffee: _____ Regular Soda: _____ Flavored water or Propel:___ ___ ___ ___

Cups of Decaf Coffee: _____ DietSoda: _____ Meals per day: _____

Cups of regular tea: _____ Crystal Light/similar: _____ Meals made at home: _____

Henry Community Health

Henry Community Health
1007 N. 16th St., Suite 220, New Castle, IN 47362
Authorization to Disclose Protected Health Information
From another Health Facility

Date _____

I hereby authorize: _____ (P)_____

Address: _____ (F)_____
to release the following information from the health records of:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

_____

Covering the period(s) of services from:
Dates of service:
_____

Information to be released:

___ History and Physical ___Discharge Summary ___Office Notes

___Operative Report ___Laboratory Report ___Radiology Report

___Radiology Film ___Other _____

Purpose of disclosure _____

Unless otherwise indicated, this authorization extends to psychiatric, alcohol and/or drug abuse, and HIV information, if any, as may be contained in the records.

Information is to be released to:
New Castle Family & Internal Medicine
2200 Forest Ridge Parkway, Suite 310
New Castle, IN 47362
(P)765-599-3400 (F)765-599-3426

I understand this authorization can be revoked at any time except to the extent that disclosures made in good faith have already occurred in reliance on this authorization. To revoke this authorization please submit request in writing to the Henry County Memorial Hospital medical records director. Include in the request your name, address, date of birth and whom the information was to be released to.
The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Once we have disclosed the information according to this authorization the information is subject to re disclosure by the recipient.

We will not condition treatment on the completion of the authorization. This consent expires 60 days from the date initiated.

Signed _____ **Date** _____
(Patient or representative)

_____
(Relationship to patient)

Witness _____ **Date** _____

Hospital Personnel fulling request _____ **Date** _____