Patient Intake Form

Patient Name_____ Date: _____

Email: _____

SS #/SIN_____ DOB_____ ☐ Male ☐ Female

Home phone_____ Cell Phone _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _____ City _____ State_____ Zip_____

Occupation: _____Employer Name: _____

Spouse or guardian's name: _____ Whom may we thank for referring you? _____

Spouse's Employer_____

Person to contact in case of emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Responsible Party

Name of the person responsible for this account: _____ Relationship to patient: _____

Address_____ Home Phone_____

E-Mail_____ Cell Phone _____

Driver's License # _____ Date of Birth: _____ Is the person currently a patient at our office? Yes No

Do you have any Medical insurance? ☐ No ☐ Yes if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Life Balance Medical Center, Inc.** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/ healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. 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. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/ insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 2020.

_____ _____

print patient/guardian name patient/guardian signature

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____

Primary Care Physician: _____

History of Present illness

Location of problem: _____

(Where is the pain/problem?)

Severity: _____

How severe is the pain/problem on a scale of 1-10 with 10 being the most severe? List your range of pain. When is it at its worst and best?

Timing: _____

(Does the pain/problem occur at a specific time?)

What other areas of your body are affected by this problem?

_____

_____

(Ex: ankle problems due to knee problems ...)

What have you tried in the past to handle your problem? :

_____

(Heat, ice, over the counter medications, prescription medications, rest, exercise, physical therapy, chiropractic adjustments, massage)

Duration: _____

(How long have you had this pain/ problem? When did it start?)

What activities have you given up or changed due to this problem? : _____

(Example: stopped climbing steps as often)

What activities increase symptoms/makes problems worse? : _____

(What makes the pain/problem worse or better? Going up and downstairs, brushing hair, etc)

Please check to indicate if you are currently (OR HAVE EVER) experiencing(ed) any of the following conditions:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Feet/Hands
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaw Problems
- ❑ Kidney Disease
- ❑ Light Bothers Eyes
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Body Temp
- ❑ Measles
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nausea
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Stomach Problems
- ❑ Strep Throat
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Suicide Attempt
- ❑ Tension
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tubes in Ears
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Name:_____DOB_____ Date:_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication Name (include OTC)	Strength/Dosage	Reason taking it

Supplement Name/Brand	Strength/Dosage	Reason taking it

Primary Care Physician: _____

Have you ever taken Fen-Phen/Redux? ☐ no ☐ yes

Are you taking any medications (prescription or over the counter) for acid indigestion?

☐ no ☐ yes if yes what type: _____

Do you have a sulfa allergy? ☐no ☐yes

Allergies/Medication Allergies:

_____

_____

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Name:_____ DOB _____ Date:_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Muscular/Skeletal		**Neurological:**		**General:**	
Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Tingling in hands or feet	1 2 3 4 5	Irritability	1 2 3 4 5
Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5	Burning in hands or feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Hypersensitivity	1 2 3 4 5	Feeling foggy	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Difficulty with Balance	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Hip Pain	1 2 3 4 5				
Knee Pain	1 2 3 4 5				
Ankle/Foot Pain	1 2 3 4 5				
Pain b/t shoulder blades	1 2 3 4 5				

Please list any allergies: _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Does your work activity mostly involve?
❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:
Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes ____ packs/day

Have you ever been exposed to mold? No _____ Yes _____ if yes, when: _____

Have you ever been exposed to chemicals (work, pesticides, etc.)? No _____ Yes ____

Sleep/Rest:

Average number of hours you sleep? : more than 10 ___ 8 to 10___ 6 to 8 __ less than 6___

Do you have trouble sleeping? Yes_____ No _____

Do you have problems falling asleep? Yes____ No _____

Do you have problems staying asleep Yes_____ No_____

Do you feel rested upon awakening? Yes_____ No_____

Do you have problems with insomnia? Yes _____ No _____

Do you snore? Yes_____ No _____

Do you use sleeping aids? Yes _____ No _____

Name:_____ DOB _____ Date:_____

Dental History:

Do you have (or had) any non-tooth colored fillings (i.e. silver or gold colored fillings)?

Yes _____ No _____ How many _____

Have you had any fillings removed? Yes _____ No _____

Do you have any root canals? Yes _____ No _____ How many? _____

Other dental fixtures? Yes_____ No_____
Describe_____

Have you had any dental work in the last 12 months? Please describe.

_____
_____
_____

Do you have a Pacemaker? NO YES
Do you have a Defibrillator NO YES
Do you have a Living will? NO YES
Do you have a DNR? (DO NOT RESUSCITATE) NO YES

IF YES PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____
Signature of person holding POA for patient Date

_____ _____ _____
Doctor's Review Signature of Doctor Date