Integrated Wellness Center

No Scent Policy

Due to SEVERE chemical allergies of patients and employees, we kindly ask that you do not enter our office if you are wearing anything scented. This includes patients, sales reps, and visitors.

We thank you for your cooperation.

I ______________________________ acknowledge that Integrated Wellness Center reserves the right to reschedule my appointment if I arrive and am wearing anything that is noticeably scented including but not limited to clothing or hair.

_________________________ __________________

Patient Name Date

Integrated Wellness Center

Patient Registration

Patient Info

Last Name ____________________ First Name ___________________ MI _____ Preferred _________________

Address ____________________________________ City ____________________ State _______ Zip ________

DOB ____________ Sex _____ SSN ________________ Marital Status _____________ Religion _____________

Primary #_______________ Home #_________________ Cell #________________ Work #__________________

Primary Language ____________ Ethnicity _______________ Primary Care Physician ______________________

Emergency Contact ________________________ Phone _________________ Relationship _________________

Responsible Party (if pt is a minor) Last Name ____________________ First Name ___________________ MI ____

Address ____________________________________ City ____________________ State _______ Zip ________

DOB ____________ Sex _____ SSN ________________ Email ____

Primary #_______________ Home #_________________ Cell #________________ Work #__________________

Primary Pharmacy Name/Phone ________________________________ Cross Streets _____________________

Secondary Pharmacy Name/Phone ______________________________ Cross Streets ____________________

Primary Insurance

Insurance Company __________________________ ID # ___________________ Group # __________________

Name of Subscriber _________________________________ DOB ____________ SSN ____________________

Address of Subscriber ____ Relationship ________________

Primary #_______________ Home #_________________ Cell #________________ Work #__________________

Employer ____

Secondary Insurance

Insurance Company __________________________ ID # ___________________ Group # __________________

Name of Subscriber _________________________________ DOB ____________ SSN ____________________

Contact Information

Please list the preferred phone/mail type of contact you would like Integrated Wellness Center to reach you to leave messages/or send information.

Preferred Phone # ______________________________ Alternate Phone # ______________________________

☐ Mail to Address Above **OR** ☐ E-Mail Address _________________________________

☐ I give my authorization to Integrated Wellness Center to invite me to use the Patient Portal using the email above.

I give permission to Integrated Wellness Center to speak with and/or leave messages regarding my appointments and/or medical care to _________________________ Phone ____________________ Relationship __________________

By signing below, I attest that the information provided above is true and accurate.

Signature of Patient or Guardian (if minor) ___________________________________ Date ________________

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT EACH VISIT

Integrated Wellness Center

CONSENT FOR TREATMENT/FINANCIAL POLICY

I authorize the staff at Integrated Wellness Center to provide medical evaluations, testing and/or treatment as necessary and advisable for my diagnosis and treatment.

As a courtesy, Integrated Wellness Center (IWC) will submit claims to primary and secondary insurance carriers for billable services only. I understand that there is no guarantee of reimbursement or payment from my insurance company. I authorize IWC to release any medical information necessary to process claims for insurance benefits and permit payment directly to IWC for services rendered. I have provided current insurance information and will continue to inform the office when I have an insurance or address change. I understand that IWC has a policy that you see a physician for the first time to establish care and this visit will NOT be coded as preventive and I am responsible for whatever my insurance does not cover; i.e. copay, coinsurance, deductible.

I understand that all copays and past due balances are due at the time of my visit. I understand there will be a $25 fee assessed for any co-payments not made at the time of service. If I choose not to pay my balance or contact the office to make payment arrangements within 30 days, I understand a $25 late payment fee will be applied to my account and my account will be turned over to an outside collection agency withing 90 days of no contact. I understand that if my balance is not paid, I agree to pay all cost incurred in connection with the collection cost and any reasonable Attorney fees. I understand that when lab work or other testing is ordered, I will receive and be financially responsible for a separate bill from the lab or designated entity.

When labs, x-rays or other tests are ordered by IWC, I understand that it is my responsibility to check with my insurance for authorized locations. IWC will not be responsible for any bill for tests done at the wrong location.

Integrated Wellness Center is a non-participating Medicare provider which means we have Opted out of Medicare and patients cannot submit their receipts to Medicare for reimbursement nor will IWC submit claims to Medicare. IWC does not accept Medicare, Medicare replacement plans, Tricare, Medicaid, Rocky Mountain Health Plans, and most HMO's. This list is not exhaustive of the insurance companies that we are not contracted with. If I have one of these plans, I understand that I am considered self-pay and payment is due at the time of service. IWC will not bill insurance if they are not in network. It is the patients' responsibility to verify eligibility and that we are in network with their plan.

Self-pay patients' payments are due at the time of service.

Payment for non-covered services is due at the time of service.

I understand that I will be charged a $25 fee if I do not give 24 hours' notice to cancel my appointment.

There will be a $30 fee for returned checked due to insufficient funds.

I consent to be contacted by telephone, regular mail or email regarding any matter related to my account.

I have read, understood and agree to the Consent for Treatment and Financial Policy listed above.

I understand that Integrated Wellness Center may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations as described in the Notice of Privacy Practices (HIPAA).

I acknowledge that I have been offered the Integrated Wellness Center's Notice of Privacy Practices (HIPAA) to review.

Signature____ Date ______________________

Printed Name ____

Revised Jan 2020

I understand it is my responsibility to check for in-network laboratories with my insurance company. I am authorizing Integrated Wellness Center to send my labs to one of their designated labs unless I take my lab order to my in-network lab.

___________________________ ______________________________
Printed Patient Name Signed Patient/Guardian Name

____
Date

FEMALES ONLY

Annual Well Woman vs Problem Visit

Your annual well woman visit is designed to prevent (screen) any problems before they occur. During your well woman exam if current or new problems are discussed, depending on the severity of the problem, your visit could change to a problem visit and one of the following may occur:

- It could be billed as a problem visit along with your well woman exam which may incur separate charges from your insurance company including but not limited to deductibles, copay and coinsurance.
- You may be asked to return for a more extensive discussion for the new problem
- You may be asked to return for your well woman exam

I understand the options that have been defined for me above & accept responsibility for services rendered at my visit. I also understand that Integrated Wellness Center will select the best option for my care.

___________________________ ______________________________
Signed Patient/Guardian Name Date

Revised 10/27/16

****Due to many of our staff and patients who have severe allergies, please avoid wearing anything scented the day of your visit.***

PATIENT IDENTIFICATION (Please Print) **Today's Date: _______________**

Marital Status: S M D Sep W If married, when? __________ If divorced, when? ___________

Your Name: ____

Date of Birth: ________________ Age: _____ Race: ____________

Address: ____

Home Phone: _____________________ Work/Cell Phone: _____________________

Religion: ____________________ Practicing: YES NO Church/Synagogue: _________________

Education: _____ years

Occupation: _________________________________

Employer: ___________________________________

Referred By: _________________________________

Primary Physician: ____________________________

REASON FOR SEEKING CARE AT INTEGRATED WELLNESS CENTER:

____

ALLERGIES TO MEDICATIONS: ____

CURRENT MEDICATIONS (Please bring list of vitamins and supplements to your visit):

DRUG NAME	DOSAGE	REASON FOR TAKING
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY (Check the appropriate column)

NO KNOWN MEDICAL PROBLEMS _____ ADOPTED _____

	You	**Who in Your Family**	**Notes**
ALLERGIES and/or Sensitivities 1. Environment: Mold/Pet 2. Food: Dairy/Fruit/Nuts/Wheat/Yeast 3. Testing done: Date:			
Abuse: Domestic, Emotional, Sexual			
AIDS/HIV			
Alzheimer's Disease			
Alcoholism			
Blood Disorder			
Asthma: Adult, Childhood, Exercise			
Autoimmune Disease (Lupus)			
Birth Defects or Inherited Diseases			
Blood Clots in Lungs or Legs			
Blood Transfusion			
Breast Problems			
Cancer			
Celiac Disease/Sprue/Gluten Intolerance			
Depression/Anxiety			
Diabetes			
Heart Disease			
Hepatitis (type________)			
High Blood Pressure			
High Cholesterol			
Kidney Problems			
Liver Disease			
Osteoporosis			
Seizures/Convulsions/Epilepsy			
Stomach/Bowel/Gallbladder Problems			
Stroke			
Thyroid Problems			
Tuberculosis			
Other Medical Problems			

MENSTRUAL AND SEXUAL HISTORY

How old were you when you first began menstruating?	____ years old
What was the first day of your last menstrual period?	/ /
Was your last period normal?	____ Yes ____ No
How many days pass between the first day of each period?	____ days pass
How long do your periods last?	____ days
How do you rate your menstrual pain?	____Mild ____Moderate ___Severe
How do you treat your pain?	
Do you have symptoms associated with your period?	____Bloating ____Cravings ____Fatigue ____Headaches ____Moodiness Treatment:
How old were you when you went through menopause?	____years old
Did you have a hysterectomy? Are your ovaries intact?	____years old ____Yes ____No
Have you ever had sex?	____Yes ____No
Are you currently sexually active?	____Yes ____No
Number of sexual partners	____Current _____Lifetime
Sexual partners are:	____Men ____Women ____Both
Present method of birth control	____Condoms ____Diaphragm ____IUD ____Spermicide ____Sponge ____Other
How long have you used this method?	____years
What forms of birth control have you or your partner used?	____Condoms ____Diaphragm ____IUD ____Spermicide ____Sponge ____Other
Have you ever had complications with birth control?	Describe:
Do you have any questions about birth control?	____Yes ____No

HOSPITALIZATIONS/SURGERIES: Anything that required anesthesia

Month/Year	Illness or Operation and Reason	Complications

GYNECOLOGIC HISTORY

Do you examine your breasts at least once a month?	____Yes ____No
Have you noticed any change in the size of your breasts?	____Yes ____No
Have you ever had a mammogram?	____Yes ____No Date:
Have you had recurrent bladder infections?	____Yes ____No
Have you had a Colonoscopy?	____Yes ____No Date:
Have you had a cholesterol test?	____Yes ____No Results:
Have you had a Bone Density Test?	____Yes ____No Date:
When was your last Pap test?	____month ____year
Have you ever had an abnormal Pap test?	____Yes ____No ____month ____year Treatment:
Did your mother ever take DES or any other hormones when she was pregnant with you?	____Yes ____No ____Uncertain
Have you ever had any infection in your tubes or ovaries?	____Yes ____No
Have you ever had any sexually transmitted infections?	____No ____Yes ____Chlamydia/Gonorrhea ____HPV ____HSV ___outbreaks per year ____Syphilis ____Trichomoniasis Treatment:
Have you ever experienced fertility problems?	____Yes ____No

PREGNANCY HISTORY

# of Pregnancies	# of Premature Births (<37 Weeks)	# of Miscarriages	# of Multiples	# of Induced Abortions	# of Living Children

Birth	Month/Year	Gender	Weight	Weeks Pregnant	Hours in Labor	Delivery Type	Anesthesia Used	Notes
1	/							
2	/							
3	/							
4	/							
5	/							
6	/							
7	/							

ANY PREGNANCY COMPLICATIONS? ____YES ____ NO
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ____ YES ____ NO

SOCIAL HISTORY

QUESTIONS	RESPONSE
Where did you grow up?	
How long have you been in Colorado?	
Where did you live before Colorado?	
What does your spouse do?	
Your occupation? Hours per week working?	
Rate your stress at work or home	HIGH MED LOW
Have you ever smoked? If yes, for how long? When did you quit?	
If you smoke now, how many packs per day?	
Do you drink alcohol?	
If you drink alcohol, what kind do you consume?	Beer Wine Whiskey
How much do you consume in a week?	
How much caffeine do you consume in a typical day?	1-2 cups 3-4 cups 5-6 cups
Do you take any street drugs?	
What type do you use?	
How much do you use in a day?	
Have you ever received individual or family counseling?	

NUTRITION/EXERCISE **GOAL WEIGHT___________**

SPECIAL DIET___________________

Do you consume food supplements?	
How many meals do you eat in a day?	1 2 3 4 5 6
In a year, how often do you diet?	Never 1-2 times 3-4 times 5+ times
Have you gained or lost weight recently?	____Gained ____Amount ____Lost ____Amount
Have you ever had an eating disorder? Is it resolved?	____Anorexia ____Bulimia ____Pica ____Yes ____No
Number of times per week you exercise	1 time 2 times 3 + times
What type of exercise do you do?	____Aerobics ____Running ____Walking ____Bicycling ____Other

Patient Name: ______________________________ Date of Birth: ______/______/______

Female Review of Current Symptoms Within Last 30 Days (Check all that apply)

Constitutional	☐ Appetite change	☐ Binge eating	☐ Fatigue
	☐ Fever	☐ Hypoglycemic episodes	☐ Insomnia
	☐ Night sweats	☐ Sugar cravings	☐ Weight gain
Eyes	☐ Blurred vision	☐ Dark circles under eyes	☐ Dry eyes
	☐ Eye irritation	☐ Eye pain	☐ Spots in vision
	☐ Sticky eyelids	☐ Swollen eyelids	☐ Watery eyelids
ENT	☐ Nasal obstruction	☐ Postnasal drainage	☐ Hearing loss
	☐ Sneezing attacks	☐ Hoarseness	☐ Ringing in ears
	☐ Bad breath	☐ Swollen tongue	☐ Itchy ears
	☐ Mouth lesions	☐ Ear drainage	☐ Vertigo
	☐ Dry mouth	☐ Ear pain	☐ Sore throat
Respiratory	☐ Asthma	☐ Cough	☐ Sputum production
	☐ Shortness of breath	☐ Sleep apnea	
	☐ Wheezing	☐ Difficulty breathing	
Cardiovascular	☐ Chest pain	☐ Irregular or skipped heartbeat	
	☐ Leg ulcers	☐ Rapid or pounding heartbeat	
Gastrointestinal	☐ Abdominal pain	☐ Belching or passing gas (x5 or greater)	☐ Vomiting
	☐ Bloating	☐ Bloody stools	☐ Black stools
	☐ Diarrhea	☐ Food intolerance	☐ Constipation
	☐ Reflux/Heartburn	☐ Hemorrhoids	☐ Nausea
Musculoskeletal	☐ Back pain	☐ Joint pain	☐ Joint swelling
	☐ Leg pain at night	☐ Muscle aches	☐ Muscle cramps
	☐ Muscle weakness	☐ Neck pain	☐ Numbness or tingling
	☐ Limited range of motion	☐ Stiffness	

Psychiatric	☐ Anger or aggressive	☐ Mood swings	☐ Panic attacks
	☐ Irritability	☐ Tearfulness	☐ Tension
	☐ Anxiety	☐ Depression	☐ PMS
Breasts	☐ Breast masses	☐ Breast skin changes	☐ Breast tenderness
	☐ Nipple discharge		
Integumentary	☐ Acne	☐ Dry skin	☐ Hair loss
	☐ Hives	☐ Rash	☐ Toenail fungus
	☐ Psoriasis	☐ Eczema	
Neurologic	☐ Confusion	☐ Decreased concentration	☐ Difficulty making decisions
	☐ Dizziness	☐ Fainting spells	☐ Headaches
	☐ Learning disabilities	☐ Memory problems	☐ Numbness
	☐ Paralysis	☐ Poor balance	☐ Poor coordination
	☐ Slurred speech	☐ Tremors	
Endocrine	☐ Abnormal menstruation	☐ Cold intolerance	☐ Decreased sex drive
	☐ Facial hair growth	☐ Heat intolerance	☐ Frequent thirst
Heme-Lymph	☐ Bleeding tendencies	☐ Frequent illness	☐ Swollen lymph nodes
Allergic-Immunologic	☐ Eczema	☐ Hives	☐ Seasonal allergies
Genitournary	☐ Blood in urine	☐ Incontinence	☐ Vaginal discharge
	☐ Painful urination	☐ Abnormal vaginal bleeding	☐ Pelvic pain
	☐ Urinary frequency	☐ Painful sex	☐ Genital itch
	☐ Urinary urgency	☐ Sexual dysfunction	☐ Severe menstrual cramping

NAME ____ **DATE**_______________________

FEMALE YEAST QUESTIONS: Please circle, check, or write in as much detail as possible

1. Is there a family history of alcoholism (parents, uncles, aunts, siblings, etc.)? YES NO
   If so, who? ____
2. Have you ever had personal history of alcohol problems? YES NO
   If so, when and how long? _____________________________________
3. When was the most recent time that you were on antibiotics for whatever the reason?
   This year, last year… ? __________________________ Reason: _____________________________
4. Were you born prematurely? YES NO
   If so, how much earlier? ____________________________
5. Did you have frequent strep throats or ear infections that required antibiotics in childhood?
   YES NO
   If so, until what age? ________________ About how many times? ________________________
6. Have you ever been diagnosed with infectious Mono or Epstein Barr Virus? YES NO
   If so, when? ____
7. Have you ever taken daily antibiotics for acne? YES NO
   If so, when? ____________________ For how long? ______________________________
8. Have you ever had antibiotics for bladder infections (cystitis, UTI's) in your life? YES NO
   If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count ______
9. Have you ever taken antibiotics for sinus infections? YES NO
   If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count ______
10. Have you ever taken antibiotics for bronchitis or pneumonia? YES NO
    If so, how many times? 0-5 ______, 6-10 ______, 11-15 _____ too numerous to count ______
11. Have you ever taken antibiotics for dental work? YES NO
    If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count ______
12. Have you ever received IV antibiotics? YES NO
    If so, when? __________________________ Reason: __________________________________
13. Have you ever taken any steroids in your life? YES NO
    If so, how many times each? Oral: ___________________ Injections (shots): ______________
14. Have you ever used birth control pills or shots? YES NO
    How long total? Years: __________________, Months: ________________________
15. Have you ever had finger or toenail fungus? YES NO
    If so, when? ____________________________ Treated with: _____________________________
16. Have you ever had vaginal yeast infections? YES NO
    If so, when? ____________________________ Treated with: _____________________________
17. Have you ever had postpartum depression? YES NO
18. Do you have sugar cravings? YES NO
19. Have you ever been treated for yeast overgrowth or candidiasis? YES NO
    If so, when? ________________________________ By whom? ____________________________
20. Have you ever lived or worked in a moldy environment? YES NO
    If so, for how long? __________________________________ When? ______________________