

# *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

**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 accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, and deductible. I understand that all copays and past due balances are due at the time of my visit. I will pay my/family balance in full in 30 days. If I choose not to pay my balance or contact the office to make payment arrangements within 90 days, I understand a \$20 late payment fee will be applied to my account and my account will be turned over to an outside collection agency. 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. *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 they 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 there will be a \$25 fee assessed for any co-payments not made 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.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Revised 5/18/16



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

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**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

**\*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?	___ years old
Are your ovaries intact?	___ 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 (Check all that apply)

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

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