



Mountain Spring Health Clinic

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Date of Birth: _____ Sex: Female / Male

Marital Status:

Married

Widowed

Separated

Single

Divorced

Partnership

Live with:

Spouse

Partner

Friends

Parents

Children

Alone

Other: _____

Occupation: _____ Hours per week: _____ Retired: Y / N

Employer: _____ Phone Number: _____

Address: _____

How did you hear about our clinic? _____

Has any other family member been a patient at this clinic? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

Name of Primary Care Physician or Healthcare Office: _____

Phone Number: _____ Fax: _____



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HEALTH HISTORY

When and where did you last receive medical or health care? _____

What was the reason? _____

Height: _____ Weight: _____ lbs. Weight 1yr ago: _____ Max Weight: _____ When: _____

When during the day is your energy the best? _____ worst? _____

What are your most important health problems? List in order of importance:

- 1) _____
- 2) _____
- 3) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

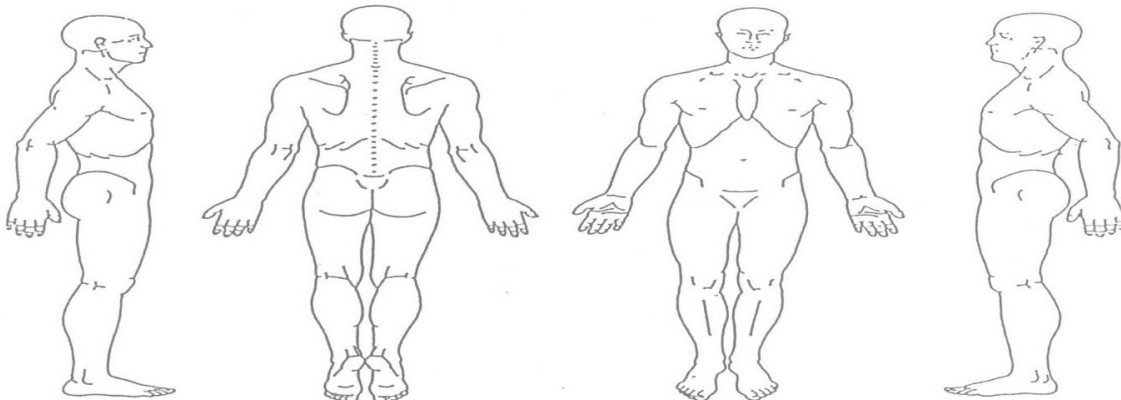
Have you had any vaccinations as an adult? Yes/No

If yes, which vaccinations and when? _____

What medications do you currently take or use?

- | | | |
|--|--|--|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Sleeping aids |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Thyroid medications | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Cortisone |

Please mark painful or distressed areas below:





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PAST HEALTH HISTORY (include dates)

Major Illnesses: _____

Major Surgeries: _____

Other Significant Trauma: _____

Check any of the following diseases you've had:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Eczema | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sexually Transmitted: _____ | | <input type="checkbox"/> Addictions: _____ | |
| <input type="checkbox"/> Cancer: _____ | | <input type="checkbox"/> Other: _____ | |

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-rays, CAT Scans, EEG, EKGs have you had?

_____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____

FAMILY MEDICAL HISTORY

- | | | | |
|-----------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Hives | <input type="checkbox"/> Allergies |

Other relevant family history? _____



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HABITS

Breakfast: _____ Lunch: _____

Dinner: _____

Snacks: _____ Drinks: _____

What food or beverage do you consume the most of or absolutely cannot live without?

What is your daily water intake? _____ oz. Source? _____
(tap, filtered, reverse osmosis, distilled)

Main interests and hobbies? _____

Do you exercise? Y / N How often? _____

If yes, what kind? _____

Do you have a religious or spiritual practice? Y / N

If yes, what kind? _____

Average 6-8 hours sleep?	Y	N	Do you drink sodas?	Y	N	P
Sleep well?	Y	N	Do you eat refined sugar?	Y	N	P
Awaken rested?	Y	N	Do you eat 3 meals a day?	Y	N	
Have a supportive relationship?	Y	N	Do you go on diets often?	Y	N	
Have a history of abuse?	Y	N	Do you eat out often?	Y	N	
Any major traumas?	Y	N	Do you add salt to foods?	Y	N	P
Use recreational drugs?	Y	N	P	Watch television?	Y	N
Been treated for drug dependence?	Y	N	How many hours? _____	Read?	Y	N
Use alcoholic beverages?	Y	N	P	How many hours? _____		
Treated for alcoholism?	Y	N	P	Enjoy your work?	Y	N
Do you use tobacco?	Y	N	P	Spend time outside?	Y	N
How many years? _____				Take vacations?	Y	N
Packs per day? _____						
Do you drink coffee?	Y	N	P			
Do you drink black/green tea?	Y	N	P			

REVIEW OF SYSTEMS

Y = Yes (current condition)

N = No (non-issue)

P = Past Problem (serious)

Mental/Emotional

Treated for Emotional Problems	Y	N	P
Mood Swings	Y	N	P
Considered/Attempted Suicide	Y	N	P
Poor Concentration	Y	N	P
Depression	Y	N	P
Anxiety or Nervousness	Y	N	P
Tension	Y	N	P
Memory Problems	Y	N	P

Neurological

Seizures	Y	N	P
Muscle Weakness	Y	N	P
Vertigo or Dizziness	Y	N	P
Loss of Memory	Y	N	P
Paralysis	Y	N	P
Numbness or Tingling	Y	N	P
Easily Stressed	Y	N	P
Loss of Balance	Y	N	P

Immune

Reactions to Immunizations	Y	N	P
Chronic Fatigue Syndrome	Y	N	P
Chronically Swollen Glands	Y	N	P
Reactions to Vaccinations	Y	N	P
Chronic Infections	Y	N	P
Slow Wound Healing	Y	N	P

Endocrine

Hypothyroid	Y	N	P
Hypoglycemia	Y	N	P
Excessive Thirst	Y	N	P
Fatigue	Y	N	P
Heat or Cold Intolerant	Y	N	P
Diabetes	Y	N	P
Excessive Hunger	Y	N	P
Seasonal Depression	Y	N	P

Skin

Rashes	Y	N	P
Acne, Boils	Y	N	P
Lumps	Y	N	P
Color Change	Y	N	P
Eczema, Hives	Y	N	P
Itching	Y	N	P
Perpetual Hair Loss	Y	N	P
Night Sweats	Y	N	P

Head

Headaches	Y	N	P
Migraines	Y	N	P
Head Injury	Y	N	P
Jaw/TMJ Problems	Y	N	P

Mouth and Throat

Frequent Sore Throat	Y	N	P
Teeth Grinding	Y	N	P
Gum Problems	Y	N	P
Dental Cavities	Y	N	P
Copious Saliva	Y	N	P
Sore Tongue/Lips	Y	N	P
Hoarseness	Y	N	P
Jaw Clicks	Y	N	P

Neck

Lumps	Y	N	P
Goiter	Y	N	P
Swollen Glands	Y	N	P
Pain or Stiffness	Y	N	P

Nose and Sinuses

Frequent Colds	Y	N	P
Stuffiness	Y	N	P
Sinus Problems	Y	N	P
Nose Bleeds	Y	N	P
Hayfever	Y	N	P
Loss of Smell	Y	N	P

<u>Eyes</u>				Angina	Y	N	P
Spots in Eyes	Y	N	P	Murmurs	Y	N	P
Impaired Vision	Y	N	P	Fainting	Y	N	P
Blurriness	Y	N	P	Palpitations/Fluttering	Y	N	P
Color Blindness	Y	N	P	Chest Pain	Y	N	P
Double Vision	Y	N	P				
Cataracts	Y	N	P	<u>Blood/Peripheral Vascular</u>			
Eye Pain/Strain	Y	N	P	Easy Bleeding or Bruising	Y	N	P
Tearing or Dryness	Y	N	P	Deep Leg Pain	Y	N	P
Glaucoma	Y	N	P	Varicose Veins	Y	N	P
Glasses or Contacts?	Y	N	P	Anemia	Y	N	P
				Cold Hands/Feet	Y	N	P
				Thrombophlebitis	Y	N	P
<u>Ears</u>							
Impaired Hearing	Y	N	P	<u>Gastrointestinal</u>			
Earaches	Y	N	P	Trouble Swallowing	Y	N	P
Ringing	Y	N	P	Change in Thirst	Y	N	P
Dizziness	Y	N	P	Change in Appetite	Y	N	P
				Nausea/Vomiting	Y	N	P
<u>Musculoskeletal</u>				Ulcer	Y	N	P
Joint Pain or Stiffness	Y	N	P	Jaundice (yellow skin)	Y	N	P
Broken Bones	Y	N	P	Gall Bladder Disease	Y	N	P
Muscle Spasms or Cramps	Y	N	P	Liver Disease	Y	N	P
Arthritis	Y	N	P	Hemorrhoids	Y	N	P
Weakness	Y	N	P	Heartburn	Y	N	P
Sciatica	Y	N	P	Abdominal Pain or Cramps	Y	N	P
				Belching or Passing Gas	Y	N	P
<u>Respiratory</u>				Constipation	Y	N	P
Cough	Y	N	P	Diarrhea	Y	N	P
Spitting-up Blood	Y	N	P	Black Stools	Y	N	P
Sputum	Y	N	P	Blood in Stool	Y	N	P
Emphysema	Y	N	P	Bowel Movements: How often? _____			
Asthma	Y	N	P	Is this a change?	Y	N	
Wheezing	Y	N	P				
Shortness of Breath	Y	N	P	<u>Urinary</u>			
Pain on Breathing	Y	N	P	Frequent Infections	Y	N	P
				Pain on Urination	Y	N	P
<u>Cardiovascular</u>				Frequency at Night	Y	N	P
High/Low Blood Pressure	Y	N	P	Increased Frequency	Y	N	P
Blood Clots	Y	N	P	Inability to Hold Urine	Y	N	P
Phlebitis	Y	N	P	Kidney Stones	Y	N	P
Swelling in Ankles	Y	N	P				

FOR MEN

Date of last prostate check-up: _____ PSA results: _____

Manual prostate exam results: _____

Please indicate if you have experienced the following in the past 3 months:

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Dribbling |
| <input type="checkbox"/> Retention of Urine | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Impotence | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Groin Pain |
| <input type="checkbox"/> Pain on Urinating | <input type="checkbox"/> Difficulty Starting Urination | | |

FOR WOMEN

Age of first period: _____ Length of cycle (days): _____ Date of last period: _____

Are you pregnant? Y / N / Maybe Age of last period (menopause): _____

Number of pregnancies: _____ Date of last gynecologic exam: _____

Number of live births: _____ Pap smear: Negative / Positive

Number of miscarriages: _____ Mammogram results: _____

Number of abortions: _____ Bone Density Scan results: _____

Have you been diagnosed with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Other: _____ | | |

Are you on hormones? Y / N If so, what? _____

Are you currently on birth control? Y / N If yes, for how long? _____

Are you having difficulty getting pregnant? Y / N If so, for how long? _____

Please indicate if you have experienced the following in the past 3 months:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Mood Swing | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Pain During Menses | <input type="checkbox"/> Pain After Menses | |
| <input type="checkbox"/> Pain Before Menses | <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Irregular Menses | |
| <input type="checkbox"/> Bleeding Between Cycles | <input type="checkbox"/> No Menses | <input type="checkbox"/> Bloating | |

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

- 1) Why did you choose to come to this clinic? _____
- 2) What do you know about our approach? _____

- 3) What three expectations do you have from this visit to our clinic?
 - i. _____
 - ii. _____
 - iii. _____
- 4) What long-term expectations do you have from working with our clinic? _____

- 5) What expectations do you have of me personally as your physician? _____

- 6) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (10 being 100% committed)
- 7) 0% 0 1 2 3 4 5 6 7 8 9 10 100%
- 8) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____
Self-destructive lifestyle habits? _____
- 9) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? _____
- 10) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will making? _____
- 11) Are you willing to follow a treatment program designed to help you return to health for at least three months? Yes / No
- 12) Are you willing to take supplements? Yes / No
- 13) Are you willing to make dietary changes? Yes / No
- 14) Are you willing to start a moderate exercise program? Yes / No



Mountain Spring Health Clinic

OFFICE POLICIES

- **Making Appointments:** Appointments are made directly with my staff or done by listening to my office hours and leaving two to three day and time possibilities. My staff or I will call you back with confirmation of your appointment day and time.
- **Cancellation Policy:** Missed appointments without prior notification are subject to a \$75.00 charge. Please give prior notice of at least 24 hours so other patients can be helped in that time slot.
- **Payment Policy:** We charge for services provided. Payment is due at the time of service. Cash, check, Visa or MasterCard are accepted. There will be a \$30.00 fee for all returned checks.
- **We do not bill** for medicinaries and typically insurance companies will not cover them under their policies. We do not accept returns on any products. Please be sure before you buy. This policy is in effect for our safety.
- **Please refrain** from wearing any perfume, cologne, aftershave, hairspray, essential oils, makeup, etc. to respect others in the clinic that may be chemically sensitive.
- **Childcare Policy:** We do not offer childcare in this clinic. Please do not leave children unattended.
- **Please notify us** when your address and/or phone number changes as soon as possible.
- **Cell Phones:** Please turn off all cell phones before entering the treatment rooms.

OUR POLICY ON INSURANCE

You will be provided with a superbill with the appropriate information and codes for you to send to your medical insurance company. It is your responsibility to be aware of the medical services covered by your insurance policy. You will pay Mountain Spring Health Clinic, LLC at the time of service and get reimbursed directly from your insurance company.

Patient Signature: _____ Date: _____



Mountain Spring Health Clinic

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent.

As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- ✓ For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- ✓ With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- ✓ To protect the public's health, such as reporting when the flu is in your area.
- ✓ To make required reports to the police, such as gunshot wounds.
- ✓ Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed.

Please check all that apply:

- Please do not phone me at home. Use this alternate phone number: _____
- Please do not phone me at work. Use this alternate phone number: _____
- Please do not leave messages on my answering machine.
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address: _____

Other request (please describe): _____

X

Patient/Guardian Signature

Date

Patient Name (Please Print. Include parent/guardian name if patient is a minor)