COMMUNITY
WHOLE HEALTH

To Our Patients:

Thank you for choosing Community Whole Health Clinic to provide you with non-emergency, primary/preventive healthcare. We pledge to you a caring, professional and sharing environment dedicated to getting you on the right track using Lifestyle Medicine interventions as a primary modality to treat common chronic conditions. Your wellness is our goal!

Your visit with our providers will involve a thorough review of your medical history to evaluate proper treatment. This questionnaire will assist the physician/advanced practice provider in determining the appropriate care for you.

This paperwork is essential to your visit. To maximize your time with the physician/ advanced practice provider, please initial that you understand this entire packet needs to be completed 30 minutes prior to your appointment time. If your paperwork is not completed prior to your appointment time, your visit may need to be rescheduled._____ (Initial)

We require you to cancel or reschedule your appointment within **24hrs** of your scheduled appointment date & time. To reschedule or cancel your appointment, please call us at (770-694-2382) or email us at info@cwhclinic.org. Cancellations after this time and no-shows are subject to the $15 cancellation fee. _____ (Initial)

Your participation in all decisions pertinent to your care is a vital part of our integrated treatment process. If you have any other questions, please feel free to ask any of our staff.

The cost for this new patient consultation/examination will be $40. This consultation fee includes select medications & certain as needed diagnostics. This fee is payable at check-in.

_____ _____

Patient/Authorized Person Signature Date

Authorization for Disclosure of Health Information

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law.

Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.
Progressive Medical Center will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Name: _____ Date: _____

Signature: _____

Guardian/ Parent name:_____ Signature: _____

My health information may be disclosed to and used by the following individual:

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: Progressive Medical Center.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ _____ _____ _____

Signature of patient or legal representative Date

PLEASE NOTE: *This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.*

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Lifestyle History Intake Form

All information provided will be kept completely confidential for the exclusive use of Community Whole Health Clinic practitioners and/or physicians in order to provide you the best possible care.

Today's Date:

Patient's Name: Mr. / Mrs. / Ms. (circle one) _____

Date of Birth: _____

Address: _____

City: _____

Zip Code: _____

Home/Cell Phone number: _____

Email address: _____

Occupation: _____

What is the BEST way to communicate with you in between office visits?

□ Home phone □ Cell phone □ Email

Is there any place you DO NOT want us to leave a message? _____

Emergency Contact Name / Relation: _____

Previous Physician's Name/number: _____

Goals and Readiness Assessment:

I would like to have this visit with the provider today because…

My overall, health goals are…

The biggest challenge(s) to reaching my health/lifestyle goals is/are:

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to	1	2	3	4	5
Modify your diet					
Take nutritional supplements each day (if appropriate)					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Do you take any vitamins or other dietary supplements? Yes/No
If yes, please list what they are, the brand and how often you take them.

Type of Supplement (e.g. vitamin D, fish oil etc.)	Brand (e.g. Nature's way)	Dose (e.g. 1000 IU)	How often? (e.g. 1 x day, 1 x week)

Please list the medications are you currently taking (prescription and/or over-the-counter):

Name of Medication	Dose	Frequency

Weight History

Height: _____

Current Weight: _____

Desired Body Weight: _____

Have you had any recent changes in your weight that you are concerned about? Yes/No

If yes, please explain: _____

Has your weight changed in the last year? Yes/No

Digestive History

Do you associate any digestive symptoms with eating certain foods? □Yes □No

If yes, please explain: _____

How often do you have a bowel movement? _____

If you take laxatives, what type/brand and how often? _____

Exercise & Other Lifestyle Habits

What type of exercise do you most enjoy (e.g. walking, running, swimming)?

How often do you exercise? For how long do you normally exercise?

□ 1-2 days / week

□ 3-4 days / week

□ 5-7 days / week

□ I don't exercise very often because I don't really enjoy it

□ I enjoy exercising but don't have time

□ Less than 30 mins. / workout

□ 30-45 mins. / workout

□ >45 mins. / workout

What are your leisure activities/hobbies? _____

Do you drink alcoholic beverages? Yes/No

If yes, how often? How many per day or per week? _____

Are you a smoker? Yes/No

Social history:

Please circle those that apply: Single Married Divorced

Please circle any of the following substances that you use regularly: Tobacco / Alcohol / Coffee / Recreational Drugs

Dental history: Please circle those that apply: Mercury filling(s) / Tooth Abscess(es) / Root Canal(s)

Meal Preparation

How many meals do you eat away from home on weekdays? _____Breakfast _____Lunch _____Dinner

How many meals do you eat away from home on weekends? _____Breakfast _____Lunch _____Dinner

List restaurants where you often eat?

3 Day Food Diary

Please keep a food diary for 3 days. Write down all the foods and drinks consumed. Please include how much (the amount you ate or serving size) and any information about how it was prepared (i.e. baked, grilled, sautéed).

DAY 1	DAY 2	DAY 3
BREAKFAST:	BREAKFAST:	BREAKFAST:
LUNCH:	LUNCH:	LUNCH:
DINNER:	DINNER:	DINNER:
SNACKS:	SNACKS:	SNACKS:

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Medical History Intake Form

Date:

Patient's Name: _____

Date of Birth: _____

What is the main problem that brought you in today? _____

How long have you been having symptoms? _____

Allergies:

Drug/Medication allergies:

Food allergies:

Environmental allergies (pollen etc.):

Past Medical History:

Have you had any of the following medical issues?

Condition	Yes	No	Current treatment	Date began	Date Resolved
ADD/ADHD					
Alcoholism/Drug					
addiction					
Allergies					
Anemia					
Anxiety					
Arthritis					
Asthma					
Autoimmune					
Cancer					
Chemical Sensitivities					
Chronic Fatigue					
Depression					
Diabetes					
Eczema					
Fibromyalgia					
GERD/reflux					

Headaches/migraines					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Irritable Bowel Syndrome					
Lyme Disease					
Mononucleosis					
Menopause					
Mental Illness					
Irritable Bowel					
Obesity					
Ovarian Cysts (PCOS)					
Psoriasis					
Prostate Disease					
Recurrent Strep Infections					
Thyroid Disease					
Other					

Hospitalizations:

If female: Do you have any of the following:

Irregular menstrual cycles? Yes / No

Extreme heavy bleeding or cramping with menstrual cycles?

Extremely light bleeding with cycles?

Breast tenderness as part of PMS symptoms?

Sugar cravings or mood swings as part of PMS symptoms?

Have you been pregnant? Yes/ No If yes, ages: _____ _____ If no, have you tried to get pregnant without success?

When was your last Menstrual Cycle?

Yes/ No

Date: _____

When was your last: Pap _____ Mammogram: _____?

Have you used birth control pills? Yes /No If yes, how long _____

If male: Do you have any of the following:

Problems attaining/maintaining an erection Yes /No

Difficulty with urination including decreased stream or increased frequency?

Family Medical History:

Mother's age (at death if deceased): _____

Any medical conditions: _____

Father's age (at death if deceased): _____

Any medical conditions: _____

Siblings' ages and medical conditions: _____

Other family members with chronic health conditions (e.g.-diabetes, heart disease, thyroid disease):

Patient/Authorized Person Initials Date Physician's Initials Date