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 for 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 a patient consultation/examination will be $30 each visit. This consultation fee includes select medications & certain diagnostics as needed. This fee is payable prior to your appointment or at check-in.

_______________________________ __________

Patient/Authorized Person Signature Date

Please Print your name: ____

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.*

Lifestyle History Intake Form

All information provided will be kept completely confidential for the exclusive use of Community Whole Health Clinic clinical providers 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:

My overall health goals:

____

____

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

____

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					

List any vitamins or other dietary supplements that you take:

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 you are 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? ___________________________

Do you drink Coffee? Yes/No
If yes, how often? How many per day or per week? ___________________________

Are you a smoker? Yes/No
If yes, how many per day/week: _____________________________

Please indicate any substances that you use regularly:

____

Social history:

Please circle those that apply: Single Married Divorced

Number of Children: ______________________

Current Occupation: ______________________________________

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

Write down all the food and drinks consumed for the past 3 days. 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:

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?

Date of your last Menstrual Cycle:

Date of 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	Provider's Initials	Date
_______________________	_________	___________________	____________