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 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.*

COMMUNITY
WHOLE HEALTH

Patient Demographics & Contact Information

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

COMMUNITY
WHOLE HEALTH

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
_____	_____	_____	_____

Lifestyle Medicine Short Assessment Form

AMERICAN COLLEGE OF Lifestyle Medicine

The following questions comprise the core metrics we propose using to capture readiness, willingness and confidence to change, as well as health behaviors that are aligned with the six pillars of lifestyle medicine. This assessment tool was adapted from the original Loma Linda University/American College of Lifestyle Medicine short form published in 2019 and updated in 2024.

Readiness to Change

On a scale of 0-10, with 0 being least and 10 being most, how important is it that you make or maintain lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10

Not Ready — Somewhat Ready — Very Ready

On a scale of 0-10, with 0 being least and 10 being most, how confident are you to make or maintain lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10

Not Confident — Somewhat Confident — Very Confident

Motivation

Please rank the top 3 areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

___ Avoidance of Risky Substances
___ Nutrition
___ Physical Activity
___ Sleep
___ Social Connectedness
___ Stress Management

Nutrition: ACLM Diet Screener 9

This brief questionnaire will ask about your **usual diet over the last 4 weeks**. Please try to answer as accurately as possible – there are no right or wrong answers. Your best guess is better than leaving a blank.
It's ok if something that you eat falls into more than one category.

Over the last 4 weeks, how often did you eat or drink the following items?

	Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day
Fruit (Apples, bananas, oranges, melon, berries, or any other fruit)						

Nutrition: ACLM Diet Screener 9

Vegetables (Cooked and raw leafy greens, tomatoes, carrots, potatoes, peas, or any other vegetables or dishes that are mostly made from vegetables)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Whole Grains (Oats, brown rice, whole grain bread or whole grain cereal, or any other 100% whole grain products)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Refined Grains or Refined Grain Products (Any items made from white flour or white rice, like bread, tortillas, baked goods or snacks, pasta, or other foods)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Packaged/Prepared, Restaurant, Takeout, or Fast Food Meals (Any store-bought dishes or meals, refrigerated or frozen, or any kind of ready-to-eat meals or dishes, take-out, or meals from a restaurant)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Sugary Foods and Beverages (Sweetened (sugar added) breakfast cereals, sweetened yogurts, candy, other desserts, or other foods with added sugar, or any sweetened beverages including soda/pop, sweetened tea or coffee drinks, energy drinks, etc.)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Salty Foods (Chips, crackers, or other salty snacks; canned soups, sauces, salad dressings, or other foods with added salt)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Fried Foods (Fried foods such as French fries, onion rings, fried chicken or other meat, fried potatoes, fry bread, tempura, or other fried foods)

Never	Less than 1x/week	1-3x/ week	4-6x/ week	1-2x/ day	More than 3x/day

Nutrition: ACLM Diet Screener 9

Which sources of protein do you eat frequently (at least a few times a week)?

Please select all that apply.

___ Beef, pork, or lamb

___ Lunchmeat, bacon, or sausage

___ Poultry or poultry-based dishes

___ Wild game (venison, elk)

___ Nuts and seeds

___ Fish or shellfish or seafood-based dishes

___ Beans/legumes, or products made from them

___ Dairy and dairy products

___ Eggs or egg-based dishes

Physical Activity: Physical Activity Vital Sign[1]

For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous physical activity (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)? _____ days

---

On those days that you engage in moderate to vigorous physical activity, how many minutes, on average, do you exercise? _____ minutes

---

During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles? _____ times per week

Sleep

Over the last 2 weeks, how many hours of sleep did you average in a 24-hour period?

Less than 4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9 or more hrs

---

Over the last 2 weeks, how often did you feel tired or have difficulty staying awake during routine tasks in the day?

Not at all	Several days	More than half the days	Nearly every day

---

Mood - PHQ-2[2] *(if not already present in electronic health record)*

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopelesss				

*Note that a recent study was done on accuracy of using the PHQ-2 for detecting depression and frequency of completing the survey. We recommend users consider the findings when determining how to screen for depression in primary care settings.[3]

Meaning and Connectedness

Over the last 2 weeks, how often have you felt like your life had purpose or meaning?

Not at all	Several days	More than half the days	Nearly every day

Over the last 2 weeks, how often have you felt connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?

Not at all	Several days	More than half the days	Nearly every day

Substance Use

In the case that something in the electronic medical record already exists to assess for the following substances, we recommend you use those assessment tools.

Have you used NICOTINE (cigarettes, e-cigarettes/vaping, chewing tobacco pouches, cigars) in the past year? _____ Yes ____ No

If you marked "YES", how many (cigarettes, e-cigarettes/vaping, chewing tobacco pouches, cigars) do you usually use a week? _____ per week

Are you currently using any over-the-counter or prescription nicotine replacement products? _____ Yes ____ No

Are you interested in quitting? _____ Yes ____ No

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your nicotine use?

0 1 2 3 4 5 6 7 8 9 10

Not Concerned Somewhat Concerned Very Concerned

Have you used ALCOHOL (12 oz beer, 5 oz wine, 1.5 oz liquor) in the past year? _____ Yes ____ No

If you marked "YES", how much alcohol do you usually use a week? _____ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your alcohol use?

0 1 2 3 4 5 6 7 8 9 10

Not Concerned Somewhat Concerned Very Concerned

Have you used MARIJUANA / THC / CBD in the past year? _____ Yes ____ No

If you marked "YES", is this marijuana prescribed by a healthcare professional? _____ Yes ____ No

If you marked "YES", how much marijuana do you usually use a week? _____ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your marijuana use?

0 1 2 3 4 5 6 7 8 9 10

Not Concerned Somewhat Concerned Very Concerned

Substance Use Cont.

Have you used Other DRUGS (cocaine, heroin, meth, opioids etc.) in the past year? _____ Yes ____ No

If you marked "YES", how much do you usually use a week? _____ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your recreational drug use?

0 1 2 3 4 5 6 7 8 9 10

Not Concerned Somewhat Concerned Very Concerned

References:
1. Golightly YM, Allen KD, Ambrose KR, Stiller JL, Evenson KR, Voisin C, Hootman JM, Callahan LF. Physical Activity as a Vital Sign: A Systematic Review. Prev Chronic Dis. 2017 Nov 30;14:E123. doi: 10.5888/pcd14.170030. PMID: 29191260; PMCID: PMC5716811.
2. Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. Journal of General Internal Medicine, 22(11), 1596-1602. 10.1007/s11606-007-0333-y
3. 1. Simon J, Panzer J, Wright KM, et al. Reduced accuracy of intake screening questionnaires tied to Quality Metrics. Annals of Family Medicine. September 1, 2023. Accessed September 19, 2024. https://www.annfammed.org/content/21/5/444.

AMERICAN COLLEGE OF Lifestyle Medicine

COMMUNITY
WHOLE HEALTH

Community Whole Health Clinic

Patient Financial Eligibility Form

SECTION I – PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

(Last Name) (First Name) (Middle Initial) ___

Address:

_____

(Street) (City/State) (Zip Code) (County)

Telephone Number:* _____ **Secondary Telephone Number:** _____

Date of Birth: _____ **Sex**: ☐Male ☐Female **Race/Ethnicity**: _____

SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY

Do you have insurance that covers?* ☐Health ☐Vision ☐Dental ☐No Insurance

If so, what services/specialty does your insurance exclude? _____.

Do you currently have Georgia Medicaid? ☐Yes ☐No **Medicare Part B?** ☐Yes ☐No

I am:* ☐**Uninsured (No insurance)** ☐**Underinsured (Do not have coverage for services being sought)**

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services.

Please provide the number of dependents in your household (include self/spouse): _____

Please provide gross family monthly income from all sources: $_____

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

"Please sign here stating you provided truthful information about your income and insurance statuses."

X _____ _____

Signature of Patient **Date**

_____

Printed Name of Person Signing