	Patient Information Sheet	CONFIDENTIAL

5191 S. Yosemite, Suite B ☯ Greenwood Village, CO 80111 ☯ Phone: (303) 577-9977 ☯ www.integrativehealthinc.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date _____ / _____ / _____	First Name	Last Name	Social Security Number — —

Gender **M F**	Date of Birth _____ / _____ / _____	Age	Marital Status **Single Married Separated Divorced**

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Alternate Phone # – **Home Work Mobile** *Circle One* ( )
Place of Employment --- Occupation ------------------------	Phone Numbers of Emergency Contact Primary ( ) Alternate ( )

Circle Insurance Coverage (Please circle one)

None Workers' Comp Auto Injury Health Insurance Company_________________________

E-Mail: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other: ____________

Chief complaint: ____
How long? ___________________________________ How often: ____
What caused this (accident, lifestyle, drug, etc.)? ____
Describe the worst it can be: ____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? __________________
Get temporary relief? ________ Fixes problem? ________ Causes side effects? ________
How does this affect your life? ____
Affect your family? ___________________________________ Affect your sleep? ____________________________
Affect your work? ____________________________________ Affect your hobbies? ____________________________
What is your goal/plan if the problem continues 5/10/20 years? ____

Complaint #2: ____
How long? ___________________________________ How often: ____
What caused this (accident, lifestyle, drug, etc.)? ____
Describe the worst it can be: ____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? __________________
Get temporary relief? ________ Fixes problem? ________ Causes side effects? ________
How does this affect your life? ____
Affect your family? ___________________________________ Affect your sleep? ____________________________
Affect your work? ____________________________________ Affect your hobbies? ____________________________
What is your goal/plan if the problem continues 5/10/20 years? ____

Other Complaints:

3) ____ 4) ____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____
Have you had acupuncture before? _____
If yes, where/who _____
Any concerns or fears about the needles? _____
If yes, what? _____
What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

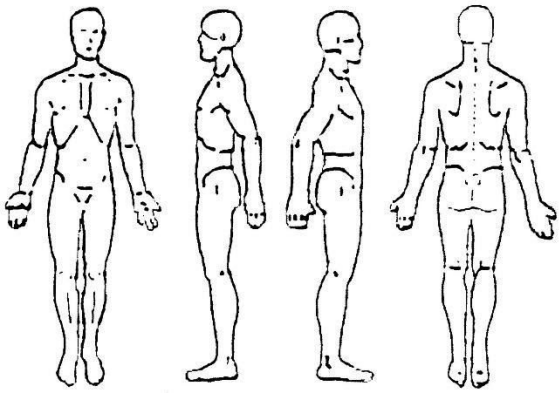
	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											

Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.
_____

MUSCULOSKELETAL		
☐ Muscle Cramps – Where?	☐ Muscle Pain / Rheumatism – Where?	☐ Arthritis – Where?
☐ Joint Swelling – Where?	☐ Tendonitis – Where?	☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Other:_____		

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Other:_____		

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Other:_____		

Additional Musculoskeletal Details/Description: _____

_____

_____

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Printed Name _____

Patient/Parent/Guardian Signature _____

Date _____

Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check **YES** or **NO** to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

_____ _____

Patient Signature Date

_____

Print Patient Name

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.

Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your *first* laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature	Date
Print Patient Name	Physician Signature

Integrative Health Inc
Experts Providing Healthcare

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

_____ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_____ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_____ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_____ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_____ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_____ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_____ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

_____
Your Printed Name

_____ _____
Signature Date

INTEGRATIVE HEALTH, INC.
WELLNESS CENTER
EXPERTS PROVIDING NATURAL HEALTHCARE
5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

_____

Your Printed Name

_____ _____

Signature Date