

*Scott Wagner*

# INTEGRATED MEDICINE

2109 India Road

Charlottesville, VA 22901

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## Patient Intake Form

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

SS #/SIN \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check appropriate Box :  Minor  Single  Married  Divorced  Widowed  Separated

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

Employer Name: \_\_\_\_\_ Spouse or guardian's name: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_

Phone \_\_\_\_\_ In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

### Responsible Party

Name of the person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Is the person currently a patient at our office? Yes No

Do you have any Medical insurance?   Yes  No if yes, complete the following:

Name of the insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Union or local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN  
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND  
BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **OFFICE LEGAL NAME, PLLC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/ healthcare services, supplies, tests, treatments, and/or medications that *have been or will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/ insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_ (SEAL) (patient signature)  
X \_\_\_\_\_ (signature of Guardian if applicable) X \_\_\_\_\_ (please print patient name)

**Health History**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**History of Present illness:** \_\_\_\_\_

**Location of problem:** \_\_\_\_\_

(Where is the pain/problem?)

**What have you tried in the past to handle your problem?:**

\_\_\_\_\_ (Heat, ice, over the counter medications, prescription)

**Severity:** \_\_\_\_\_

medications, rest, exercise, physical therapy, chiropractic adjustments, massage)

How severe is the pain/problem on a scale of 1-10 with 10 being the most severe? List your range of pain.  
When is it at

its worst and best?

Timing: \_\_\_\_\_

(Does the pain/problem occur at a specific time?)

What other areas of your body are affected by this problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Ex: ankle problems due to knee problems ...)

Duration:

\_\_\_\_\_  
(How long have you had this pain/ problem? When did it start?)

What activities have you given up or changed due to this

problem?:

\_\_\_\_\_  
(Example: stopped climbing steps as often)

What activities increase symptoms/makes problems worse?:

\_\_\_\_\_  
(What makes the pain/problem worse or better? Going up and

down stairs, brushing hair, etc)

Are you on any medications now for this problem? \_\_\_\_\_

**Past Medical History**

(Have you ever had the following: (circle "yes" or "no" / leave blank if you are uncertain.)

Measles..... NO YES Anemia.....NO YES Back Trouble.....NO YES

Hepatitis..... NO YES

Mumps..... NO YES Bladder Infection.....NO YES High Blood Pressure.....NO YES

Ulcer.....NO YES

Chicken Pox..... NO YES Epilepsy.....NO YES Low Blood Pressure.....NO YES Kidney

Disease.....NO YES

Whooping Cough... NO YES Migraine Headaches. NO YES Hemorrhoids.....NO YES Thyroid

Disease.....NO

YES  
Scarlet Fever..... NO YES Tuberculosis.....NO YES Date of Last Chest X-Ray \_\_\_\_\_ Bleeding

Tendency.....NO

YES

Diphtheria..... NO YES Diabetes.....NO YES Asthma.....NO YES Any Other

Disease.....NO YES

Small pox..... NO YES Cancer..... .NO YES Hives of Eczema.....NO YES ( Please List):

Pneumonia..... NO YES Polio..... NO YES AIDS & HIV.....NO YES

Rheumatic Fever... NO YES Glaucoma.....NO YES Infectious Mono.....NO YES

Arthritis..... NO YES Hernia.....NO YES Bronchitis.....NO YES

Venereal Disease... NO YES Blood or Plasma Mitral Valve Prolapse....NO YES \_\_\_\_\_

Transfusion.....NO YES Stroke.....NO YES

**Previous Hospitalizations/Surgeries/Serious Illnesses**  
State

When?

Hospital, City,

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication:** (include non-prescription)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?                      NO                      YES  
Are you taking any medications (prescription or over the counter) for acid indigestion?  
O yes   O no   if yes what type: \_\_\_\_\_

**Do you have a sulfa allergy?**                      NO                      YES

**Allergies/Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLINICIAN SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**REVIEWED:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_  
\_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Social History:**

**Marital Status**      Single: \_\_\_\_\_      Married: \_\_\_\_\_      Separated: \_\_\_\_\_      Divorced: \_\_\_\_\_      Widowed: \_\_\_\_\_  
**Use of Alcohol**      Never: \_\_\_\_\_      Rarely: \_\_\_\_\_      Moderate: \_\_\_\_\_      Daily: \_\_\_\_\_  
**Use of Tobacco**      Never: \_\_\_\_\_      Rarely: \_\_\_\_\_      Moderate: \_\_\_\_\_      Daily: \_\_\_\_\_  
**Use of Drugs**      Never: \_\_\_\_\_      Type/Frequency: \_\_\_\_\_

**Excessive Exposure**  
At home or at work to: Fumes: \_\_\_\_\_ Dust: \_\_\_\_\_ Solvents: \_\_\_\_\_ Airborne Particles: \_\_\_\_\_ Noise: \_\_\_\_\_

**Family Medical History:**

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Spouse:	_____	_____	_____

Children:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months  
 1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

<u>Muscular/Skeletal</u>		<u>Neurological:</u>		<u>General:</u>	
Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Tingling in hands or feet	1 2 3 4 5	Irritability	1 2 3 4 5
Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5	Burning in hands or feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Hypersensitivity	1 2 3 4 5	Feeling foggy	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Difficulty with Balance	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Hip Pain	1 2 3 4 5				
Knee Pain	1 2 3 4 5				
Ankle/Foot Pain	1 2 3 4 5				
Pain b/t shoulder blades	1 2 3 4 5				

Do you have a Living will?.....NO YES Do you have a DNR? (DO NOT RESUSCITATE).....NO YES

**IF YES PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE.**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_  
Signature of the Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person holding POA for patient

\_\_\_\_\_  
Date

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Doctor's Review

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Signature of Doctor

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Date