CORNERSTONE
Integrated Healthcare

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Comprehensive Health History Forms

Patient Information

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#:_____ DOB: _____ Age: _____

Status : □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

What specific condition prompted you to choose us for your healthcare needs?

_____

_____

Informed Consent

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinical services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or coporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

_____
Patient Signature

HIPAA Consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

_____ _____
(patient signature) (Date)

Insurance Information

Who is responsible for this account? □ Self □
Other:_____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #:_____ Group #:_____

Is the patient covered by additional Insurance? □ Yes □ No

Subscribers Name: _____

DOB:_____ SS#:_____

Relationship to Patient: _____

Insurance Company: _____

Assignment and Release

I understand and agree that (regardless of whatever health or medical benefits I have), **I am ultimately responsible to pay CORNERSTONE INTEGRATED HEALTHCARE, LLC, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided**.

I hereby authorize payment of any health insurance or medical plan benefits directly to CORNERSTONE INTEGRATED HEALTHCARE, LLC, for medical services rendered and for any supplies, tests or medications provided.

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 CORNERSTONE INTEGRATED HEALTHCARE, LLC, all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that CORNERSTONE INTEGRATED HEALTHCARE, LLC, can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to CORNERSTONE INTEGRATED HEALTHCARE, LLC, as a result of services rendered by CORNERSTONE INTEGRATED HEALTHCARE, LLC, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer.

This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

Patient Name _____ Patient Signature _____ Date_____

Current Medications

Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

_____

_____

_____

Medication Allergies: _____

Reaction? _____

Food Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)*

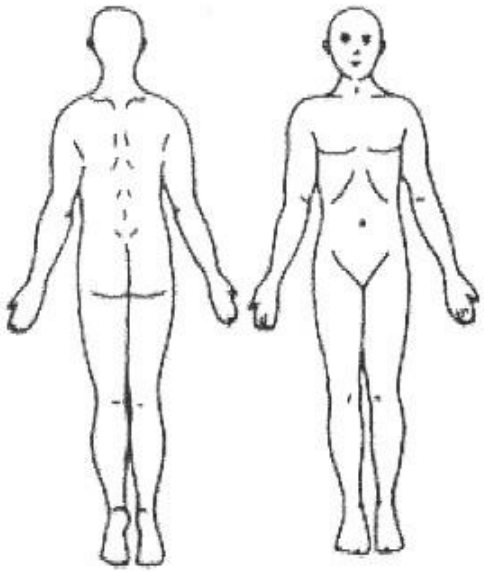
□ Yes □ No If yes, where located _____

Demographics:

Race: □ White □ African American □ Asian □ Other
□ American Indian □ Pacific Islander

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

□ You can receive a clinical summary online. Please check here if you would like to receive this summary.



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins&Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Current Condition

When did this condition(s) begin? _____

_____

Has it occurred before? □ Yes □ No When?
_____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____

If this is accident or work related, have you reported it? □ Yes □ No

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you received for your condition?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other
_____

Please list Current and Ongoing Problems in Order of Severity:

1. Problem
   _____
   □ Mild □ Moderate □ Severe

   Treatment/Approach
   _____
   Success: □ Excellent □ Good □ Fair

2. Problem
   _____
   □ Mild □ Moderate □ Severe

   Treatment/Approach
   _____
   Success: □ Excellent □ Good □ Fair

3. Problem
   _____
   □ Mild □ Moderate □ Severe

Previous Care

What Type of Treatment have you received for this condition?
_____

Did it Resolve the Condition: □ Yes □ No Explain: _____

Primary Care Physician's Name _____

Clinic Name _____ Phone Number _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Patient Name _____ Patient Signature _____ Date_____

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** □ **Light Activity** □ **Moderate Activity**

□ **Heavy Activity** □ **Vigorous Activity**

Please check all that apply:

□ Do you currently or have previously used Tobacco – □ Yes □ No

Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? _____

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day:

_____

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc) _____

Work Activity

Labor Activity:

□ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures:

□ Bending □ Climbing □ Kneeling □ Pulling
□ Pushing □ Reaching □ Sitting □ Standing
□ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level:

□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

Hours per week _____ Mostly □ Sitting □ Walking □ Standing

Work Environment:

□ Difficult □ Enjoyable □ Relaxed □ Stressful

Daily Activities

Effects of Current Condition on Daily Performance

Circle Each area of life that is effected

Bending
Carrying
Climbing
Concentrating
Computer Work
Dancing
Doing Chores
Dressing
Driving
Gardening
Jumping
Lifting
Playing Sports
Pushing
Reading
Rolling Over
Sexual Activity
Shoveling
Sitting
Sitting to Standing
Sleeping
Standing
Walking
Working

Health History Please check all that apply (past or present) / Circle **CURRENT** Conditions

___ ADD
___ AIDS/HIV
___ Alcoholism
___ Allergies
___Alzheimer's
___ Anemia
___ Anorexia
___ Arthritis
___ Asthma
___ Atopic Dermatitis
___ Bleeding Disorders
___ Blood Clot
___ Bronchitis
___ Bulimia
___ Cancer
___ Cerebral Palsy
___ Chemical Dependency
___ Chest Pain
___ Chronic Fatigue Syndrome
___ Crohn's/Colitis
___ CRPS (RSD)
___ Constipation
___ CVA (Stroke)
___ Cystic Kidney Disease
___ Depression
___ Diabetes (*insulin*)
___ Diabetes *(non insulin*)
___ Ear Infections
___ Eczema
___ Emphysema
___ Epilepsy/Convulsions
___ Fibromyalgia
___ Fractures
___ Glaucoma
___ Goiter
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Heart Failure
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Lesions/Shingles
___ High Blood Pressure
___ High Cholesterol
___ Hypertension
___ Influenza Pneumonia
___ IBS (*Irritable Bowel Syndrome*)
___ Kidney Stones
___ Liver Disease
___ Lung Disease
___ Lupus Erythema (*Discoid*)
___ Lupus Erythema (Systemic)
___ Lyme Disease
___ Migraine Headaches
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Osteoporosis
___ Pacemaker
___ Parkinson's Disease
___ Pinched Nerve
___ Pleurisy
___ Polio
___ Prostate Problems
___ Prosthesis
___ Psoriasis
___ Psychiatric Care
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Scarlet Fever
___ Scoliosis
___ Seizure Disorder
___ Sickle Cell Anemia
___ Sinusitis
___ Sleep Apnea
___ Spina Bifida
___ Stroke
___ Swelling Feet
___ Thyroid Problems
___ Tuberculosis
___ Tumors, Growths
___ Ulcers
___ Unspec. Pleural Effusion
___ Vertigo
___ Whooping Cough
___ Other: _____
_____

Patient Name _____ Patient Signature _____ Date_____