Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

Welcome to Our Office!

We're looking forward to meeting you and promise to work hard to make sure that this is a great experience! Since you are going to be sharing some personal information with us on the next few pages, we thought it would only be fair to share a few things about us with you.

Genesis Integrative Medicine is what we believe the modern health care consumer is looking for. You've spoken and we've listened! Most people don't like to drive all over town seeing one doctor here and then another doctor there. Most times those doctors aren't even talking to one another and don't always often agree on what is the best treatment option. That can be frustrating for the patient! Other people have told us that they wish the alternative health care doctors would work together with the medical doctors to combine the best of both worlds to get the absolute best result for the patient.

At Genesis Integrative Medicine we've done both! Our doctors and health care practitioners work together under one roof as a team to create the best plan of action for the patient. Our medical team designs a personalized plan that may include – physical therapy, chiropractic care, trigger point injections, stem cell therapy, platelet rich protein (PRP) injections, joint injections, orthotics and cold laser therapy. We also regularly consult with patients on diet and nutrition and have InvisaRed® weight loss technology that removes fat and reduces cellulite, stretch marks and scarring.

Our exam is very thorough and includes the latest in cutting-edge technology like digital x-ray and diagnostic ultrasound to make sure that we are as accurate as possible with our diagnosis and treatment. We will make sure that you completely understand what the cause of your problem is and if we think we can help you. If not, we will do our best to try and find you someone that can.

We appreciate you trusting us with your health and your goals. We're grateful to be part of your health journey. Before your first visit, we encourage you to spend some time on our website. www.GenesisIntegrativeMed.com. It's a great way to learn more about us and to answer some of the questions you might have.

Again, welcome to our office!

In Health.

Dr. Nathan Conroy
Clinic Director

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

New Patient Intake Form

Patient Information

Name:_____ Nickname:_____ DOB: _____ Age:_____

Phone: _____ Sex: □ F □ M SS#: _____ Are you pregnant? (circle): □ Y □ N □ Unsure

Marital Status: □ Single □ Married □ Domestic Partner □ Widowed □ Divorced Name of Significant Other:_____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Emergency contact: _____ Phone: _____

How did you hear about our office?_____

****

***For Minors*: Responsible Party** Person responsible for this account _____

Relationship to Patient _____ Phone _____

Address _____ E-Mail _____

Driver's License # _____ DOB: _____ 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_____

DOB _____ SS#_____ Name of Employer_____

Insurance Company_____ Group #_____ ID # _____

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 **Genesis Integrative Medicine** 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 or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

Reason for today's visit

Primary Complaint (What brings you in today?): _____

When did this start?:_____

Was there a specific event/injury?: _____

What makes it worse? _____

What makes it better? _____

How would you describe the pain?: ☐ Achy ☐ Burning ☐ Cold ☐ Cramping ☐ Heavy ☐ Hot ☐ Numb

☐ Pins & needles ☐ Radiates ☐ Sharp ☐ Shocks ☐ Stabbing ☐ Swollen ☐ Throbbing ☐ Tingling ☐ Travels

How would you rate the pain *now* from 0 (best) to 10 (worst): 0 1 2 3 4 5 6 7 8 9 10

How would you rate the pain *at its worst* from 0 (best) to 10 (worst): 0 1 2 3 4 5 6 7 8 9 10

When does it bother you most?: ☐ Morning ☐ Midday ☐ Night ☐ Consistent all day

Is the pain: ☐ Constant (100% of time) ☐ Frequent (50-75% of time) ☐ Occasional (25-50% of time) ☐ Infrequent (<25%)

Any other health professionals seen for this problem:_____

_____

What treatments have you tried?

☐ Aspirin ☐ Aleve ☐ Tylenol ☐ Ibuprofen ☐ Motrin ☐ Gabapentin ☐ Lyrica ☐ Cymbalta ☐ Neurontin

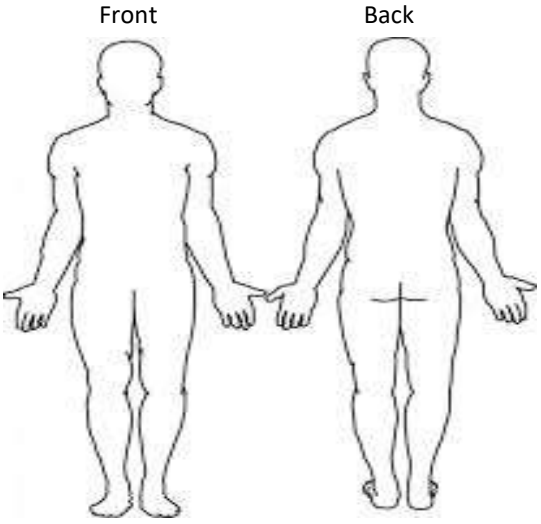
☐ Physical Therapy ☐ Chiropractor ☐ Massage ☐ Creams ☐ Injections ☐ Surgery ☐ Other:_____

Which treatments helped?: _____

Does it interfere with…: ☐ Family ☐ Relationships ☐ Work ☐ Exercise ☐ Recreational activities ☐ Sleep

What specific activities does this problem prevent you from doing, either partially or totally, that you would like to be able to do again?_____

Please circle the bothersome or painful area(s):



On a scale of 1-10, 10 being the most, rate your level of commitment to getting rid of this problem:
0 1 2 3 4 5 6 7 8 9 10

What do you do in a typical day? _____

What would be your # 1 goal from visiting this clinic ? _____

_____

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

Secondary Complaint (What else brings you in today?): _____

When did this start?:_____

Was there a specific event/injury?: _____

What makes it worse? _____

What makes it better? _____

How would you describe the pain?: ☐ Achy ☐ Burning ☐ Cold ☐ Cramping ☐ Heavy ☐ Hot ☐ Numb

☐ Pins & needles ☐ Radiating ☐ Sharp ☐ Shocks ☐ Stabbing ☐ Swollen ☐ Throbbing ☐ Tingling ☐ Travels

How would you rate the pain *now* from 0 (best) to 10 (worst): 0 1 2 3 4 5 6 7 8 9 10

How would you rate the pain *at its worst* from 0 (best) to 10 (worst): 0 1 2 3 4 5 6 7 8 9 10

When does it bother you most?: ☐ Morning ☐ Midday ☐ Night ☐ Consistent all day

Is the pain: ☐ Constant (100% of time) ☐ Frequent (50-75% of time) ☐ Occasional (25-50% of time) ☐ Infrequent (<25%)

Any other health professionals seen for this problem:_____

_____

What treatments have you tried?

☐ Aspirin ☐ Aleve ☐ Tylenol ☐ Ibuprofen ☐ Motrin ☐ Gabapentin ☐ Lyrica ☐ Cymbalta ☐ Neurontin

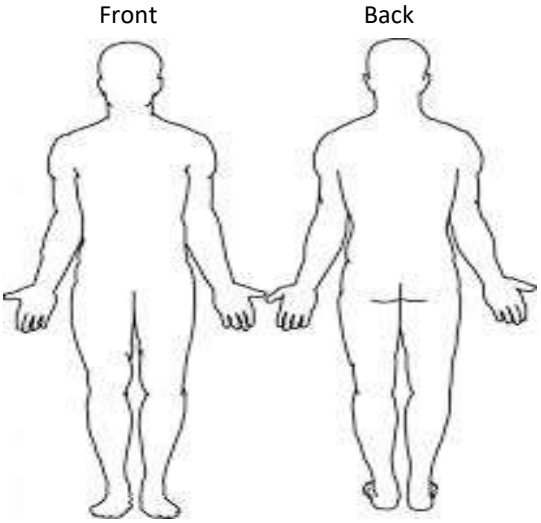
☐ Physical Therapy ☐ Chiropractor ☐ Massage ☐ Creams ☐ Injections ☐ Surgery ☐ Other:_____

Which treatments helped?: _____

Does it interfere with…: ☐ Family ☐ Relationships ☐ Work ☐ Exercise ☐ Recreational activities ☐ Sleep

What specific activities does this problem prevent you from doing, either partially or totally, that you would like to be able to do again?_____

Please circle the bothersome or painful area(s):



On a scale of 1-10, 10 being the most, rate your level of commitment to getting rid of this problem:

0 1 2 3 4 5 6 7 8 9 10

What other health problems concern you today?: _____

_____

_____

_____

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

Please indicate which of the below you have experienced in the last 1-2 months

General	Yes	No
Fatigue	☐	☐
Malaise	☐	☐
Weakness, tiredness	☐	☐
Lightheadedness	☐	☐
Irritability	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Digestive issues	☐	☐
Feeling foggy	☐	☐
Forgetfulness	☐	☐
Sexual Dysfunction	☐	☐

Neurological		
Headaches	☐	☐
Migraines	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Tingling	☐	☐
Pins/needles in hands/feet	☐	☐

Muscular/Skeletal	Yes	No
Muscle Aches	☐	☐
Fibromyalgia	☐	☐
Arthritis	☐	☐
Joint Pain	☐	☐
Low Back Pain	☐	☐
Neck Pain	☐	☐
Wrist/Hand Pain	☐	☐
Elbow Pain	☐	☐
Shoulder Pain	☐	☐
Hip Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Pain b/t shoulder blades	☐	☐
Jaw Pain	☐	☐

Eyes/Ears/Nose/Throat/Respiratory	Yes	No
Asthma	☐	☐
Stuffy Nose	☐	☐
Hay Fever	☐	☐
Sore throat	☐	☐
Chronic Cough	☐	☐
Chest Congestion	☐	☐
Frequent Sneezing	☐	☐
Itchy/Watery Eyes	☐	☐
Drainage	☐	☐
Earache, pain, or infections	☐	☐
Itching	☐	☐
Hoarseness	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Perceived Health: On a scale of 1-10 (1=poor, 10=excellent), please rate how well you are doing with the following:

Exercise:_____ Sleep: _____ Diet: _____ Stress Level: _____ Water Intake: _____ Energy level: _____

Personal Health Goals

In general, what are your personal health goals? (Check all that apply)

☐ Improved Nutrition
☐ Improved energy
☐ Improved sleep
☐ Improved posture
☐ Improved outlook
☐ Get off medications
☐ Weight loss/ Fat loss
☐ Increase lean muscle
☐ Increase bone density
☐ Reduce stress
☐ Lower cholesterol
☐ Lower blood pressure
☐ Increased range of motion
☐ Increased activity
☐ Start exercising
☐ Play rec sports
☐ Look better
☐ Feel better
☐ Decreased or no pain
☐ Play with kids/grandkids

****

Past/Present Medical History

(Have you ever or do you currently suffer from any of the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

AIDS/HIV…….. Yes / No
Allergies……Yes / No
Anemia……..Yes / No
Anxiety…….. Yes / No
Arthritis…….. Yes / No
Asthma…….. Yes / No
Autoimmune dx------ Yes / No
Balance Problems…..Yes / No
Bladder infections…. Yes / No
Bleeding tendency…. Yes / No
Cancer…….. Yes / No
Chronic Pain…….. Yes / No
Chicken Pox…….. Yes / No
COPD…….. Yes / No
Dec bone density……Yes / No
Depression……..Yes / No
Diabetes…….. Yes / No
Disc issues……..Yes / No
Eczema…….. Yes / No
Epilepsy…….. Yes / No
Fibromyalgia……Yes / No
Food sensitivities……. Yes / No
Frequent colds…….. Yes / No
Glaucoma……Yes / No
Gout……Yes / No
Heartburn/reflux……Yes / No
Heart disease……Yes / No
Hemorrhoids…….. Yes / No
Hepatitis…….. Yes / No
Hernia…….. Yes / No
High blood pressure…Yes / No
High cholesterol…….Yes / No
Itching……Yes / No
Kidney disease…….. Yes / No
Lack of energy……Yes / No
Loss of bowel/bladder control..
…….. Yes / No
Liver disease…….. Yes / No
Lung disease…….. Yes / No
Measles…….. Yes / No
Mono……..Yes / No
Mumps……..Yes / No
Pneumonia…….. Yes / No
Polio…….. Yes / No
Rheumatic fever……..Yes / No
Rheumatoid arthritis……Yes / No
Sciatica……..Yes / No
Sinus issues……Yes / No
Sleep problems……Yes / No
STD's……..Yes / No
Stroke…….. Yes / No
Tension/stress…….. Yes / No
Thyroid disease……Yes / No
Tuberculosis……..Yes / No
Ulcers……..Yes / No
Vascular problems…….. Yes / No
Walking problems……..Yes / No
Other: _____
_____
_____

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

Previous Hospitalizations/Surgeries/Serious Illnesses and when?
_____
_____
_____

Traumas: Please list *any* accidents or traumas you have suffered (mild/major) in your lifetime (falls, sports, childhood):
_____
_____

Allergies: _____
_____

Current Medical Conditions you would like the Nurse Practitioner to know about:_____
_____
_____

Current Medications/Supplements: _____
_____
_____
_____

Social History

Primary care provider:_____

Occupation:_____

Recreational activities:_____

Exercise: Yes / No How many times a week: _____

Use of tobacco (smoke/chew): Yes / No How often/much: _____

Use of alcohol: Yes / No How often/much: _____

Use of recreational drugs: Yes / No How often/much: _____

Excessive exposure at home or work to (circle if yes):

• Fumes • Dust • Particles • Excessive noise • Solvents • Sitting at a desk • Repetitive movements • Standing

***Relevant* Family Medical History:**

	Age	Disease(s)	If deceased, cause of death
Mother:	_____	_____	_____
Father:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Genesis Integrative Medicine
1881 S Randall Rd ♦ Geneva IL 60134

****

Informed consent for treatment/diagnostic imaging

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 certify that I am the patient or legal guardian of the above listed patient. I authorize this office and its staff to examine and treat my condition as the medical professionals see fit, including having diagnostic x-ray examination if necessary.

_____ _____
Signature of the Patient, Parent or Guardian Date

****

For Females: Verification of pregnancy status

This is to certify that, to the best of my knowledge, I am not pregnant, and give my permission to have diagnostic x-ray if necessary (If you are unsure of your pregnancy status, it is very important that you inform your care provider prior to any diagnostic imaging).

_____ _____
Signature of the Patient, Parent or Guardian Date

****

Release of Information:

This is a confidential record of my medical history and pertinent personal information. The doctor/nurse practitioner reserves the right to discuss this information with medical and allied health professionals per this informed consent. Copies of this record can only be released by your written authorization. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request:

_____ _____
Print name Date

_____ _____
Signature of the Patient, Parent or Guardian Date

****

Care of a minor:

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care determined by a physician/nurse practitioner to be necessary for the welfare of my child while said child is under the care of the medical staff of Genesis Integrative Medicine and I am not reasonably available by telephone to give consent.

This authorization is effective from (today's date)_____ until revoked by me.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Signature Date

_____ _____
Reviewing Provider Signature (NP) Date