Healthcare Partners
Family Medicine

Printed Patient Name: _____

WELCOME TO HEALTHCARE PARTNERS!

As a new patient, we would appreciate you familiarizing yourself with the policies of our practice before your first office visit. As a practice which centers on the Holistic approach to medicine, we try to view your body as a whole. This means that we will consider all systems of the body and how they react with one another to achieve homeostasis. Our new patients are thoroughly evaluated before we are able to make the best decisions possible regarding your care.

Initial office visits protocol for patients seeking to establish a primary care physician

On the 1st office visit as a "New Patient," is a meet & greet visit to discuss most important complications. For your first office visit we request that you bring all the medications or prescriptions (NOT Supplements) you are currently taking. The nurse will ask many questions regarding any medical conditions you have in order to obtain a thorough background. This may include questions regarding any tests or treatments you may have undergone, whether or not they were successful and any related complications. The nurses are highly trained and though some of the questions may seem irrelevant please be confident that all the questions are necessary in order to obtain a full evaluation. If you are taking supplements and are interested in your nutrient status, please inform the nurse.
Patient initial _____

The 2nd office visit is for annual physicals, you will be requested to give a urine sample. Please do not void your bladder until you have checked in and been given the urine test cup. On this visit, the doctor will perform a complete physical examination on you to determine which laboratory or diagnostic testing may be required to provide the most effective care for you.
Patient initial _____

The 3rd office visit is devoted to explaining all of the blood work results. We explain the results to you in layman's terms so you will obtain a complete understanding of them and what treatment options are available for addressing your particular needs.
Patient initial _____

The 4th office visit is devoted to explaining all other diagnostic testing (i.e. x-rays, ultrasounds, etc.) that were performed. Again, we will explain all results in layman's terms and various treatments options available.
Patient initial _____

The 5th office visit is devoted to reviewing the results of all alternative tests that were performed. During this visit you may bring any supplements that you are taking for the doctor to review. He will discuss with you the quality of these supplements and how they are contributing to your well- being. If an alternative testing or supplemental review is not necessary, then other health issues may be addressed during this visit instead.
Patient initial _____

Bloodwork is generally repeated every four (4) months until results are in the normal range. Diagnostic testing generally repeated every year to evaluate any new changes that may occur or any disease progression (These tests maybe repeated earlier if re-evaluation is necessary for critical levels).

Patient who has a primary care physician but interested in pursuing alternative treatment for a particular concern ONLY.

I confirm that I wish my first office visit to be problem specific and that I am seeking alternative treatment for this condition. However, based on the physician's findings, I understand that he may perform a physical and order blood work or ancillaries such as ultrasounds. Should this be the case, it will be my responsibility to coordinate the orders with my primary physician and to ensure that HEALTHCARE PARTNERS gets copies of the results. Furthermore, I understand that the office visit protocol above will then apply and by my initials confirm this understanding.
Patient initial _____

Healthcare Partners
Family Medicine

This packet must be completed in ITS ENTIRETY. It will be returned to you if incomplete.
An appointment will be scheduled when we have the completed packet.
NOTE: Please bring insurance cards and photo ID with you. These will be scanned into your electronic record at check-in.

PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT NAME: _____ **D.O.B.** _____ **AGE:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **SEX:** _____

PHONE: _____ **CELL PHONE #:** _____

SSN: _____ **DRIVER'S LICENSE#:** _____

EMAIL ADDRESS: _____ **FAX:** _____

ALTERNATE ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER: _____ **PHONE:** _____

MAILING ADDRESS: (Same as above**)** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

WITH WHOM MAY WE SHARE YOUR MEDICAL RECORDS AND/OR NOTIFY IN CASE OF EMERGENCY?

NAME: _____ **RELATION:** _____ **PHONE:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY INSURANCE: _____ **PHONE #** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

POLICY #: _____ **GROUP:** _____

INSURED NAME: _____ **INSURED D.O.B.:** _____

SECONDARY INSURANCE: _____

MAILING ADDRESS: _____ **PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

POLICY #: _____ **GROUP:** _____

INSURED NAME: _____ **INSURED D.O.B.:** _____

- I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS.
- I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO "HEALTHCARE PARTNERS FAMILY MEDICINE FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE" IF THEY FILE AN INSURANCE CLAIM.
- I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID IN FULL OR PARTIALLY PAID BY THE INSURANCE CARRIER.

SIGNATURE: _____ **DATE**: _____
REFERRAL SOURCE: _____

Healthcare Partners
Family Medicine

HEALTH QUESTIONNAIRE

NOTE: Read carefully – fill in or circle information as completely as possible. The information provided by this questionnaire will become a permanent part of your records at our Center.

Today's Date:

IDENTIFICATION

LAST NAME: FIRST NAME: M.I.:

BIRTHDATE: AGE: GENDER:

ADDRESS:

HEIGHT: FT. IN. WEIGHT: LBS.

NAME & ADDRESS OF YOUR PHYSICIAN (MD, DO, OR DC)

DATE OF LAST CONSULTATION WITH FAMILY PHYSICIAN

DEMOGRAPHIC BACKGROUND

MARITAL STATUS: MARRIED SINGLE DIVORCED: How Long? ____ WIDOWED: How Long? ____

NUMBER OF MARRIAGES: _____ NUMBER OF CHILDREN? _____

Adult Children's Name	Address	Phone

List additional children's names, addresses and phone at the back or on a separate paper

WORK TYPE (if retired, previous work type):

WORK STATUS: FULLTIME PART TIME RETIRED If retired, how long? _____

Do you drink alcohol, beer, or wine? NO YES
If yes, are you an occasional___moderate ___or heavy ___drinker?
If no, have you in the past? NO YES
If yes, were you an occasional___moderate ___or heavy __drinker?
If you quit drinking, how long ago? YEAR: _____

Do you currently smoke or chew tobacco? NO YES
If yes, how many packs per (fill out one) day ____or week ___, or month ___
If NO, have you in the past YES NO
If YES, how many packs per (fill out one) day ____or week ___or month___
If you quit smoking, how long ago? YEAR: _____

RECREATIONAL DRUG USE: NO YES
If yes: Name of drug: _____ how long for _____

CAFFEINE USE: NO YES **If yes, how many:**
cups of coffee per day _____
cola cans per day _____

EXERCISE: None Light Moderate Strenuous #Times per week: ____

Able to perform activities of daily living? YES NO

Do you suffer from depression? YES NO

Purpose of Visit (check appropriate one): ☐ **Problem Only** ☐ **Establish with Primary Care Physician**

MAJOR COMPLAINTS AND **HOW LONG THEY HAVE BEEN PRESENT**, (i.e., HEART DISEASE x 10 OR KIDNEY DISEASE x 5 YEARS)

_____

_____

IN YOUR OWN WORDS DESCRIBE YOUR MOST PERSISTENT MEDICAL PROBLEM WITH SYMPTOMS, ITS DURATION AND RESPONSE TO PREVIOUS TREATMENTS: (Can use the back page or separate paper.)

Reviewed by Physician: _____(Initials) **Review Date: _____**

ILLNESS HISTORY:

Have you ever had or been diagnosed to have: (check all that apply and give last date diagnosed if known)

YES	PROBLEM	Date Diagnosed	YES	PROBLEM	Date Diagnosed
	Alcoholism				
	Allergies			Herpes (fever blisters, shingles)	
	Anemia			High blood pressure	
	Arthritis, degenerative			Hypoglycemia – low blood sugar	
	Asthma			Infectious mononucleosis	
	Bipolar disorder			Kidney stones/problems	
	Digestive Problems			Liver problems	
	Stomach problems			Migraines	
	Cancer – please specify:			Obesity – more than 20 lbs. or	
	1.			Osteopenia	
	2.			Osteoporosis	
	3.			Osteoarthritis	
	4.			Phlebitis	
	5.			Pleurisy-	
	6.			Pneumonia	
	Cataracts			Polyps in colon	
	Chronic Abdominal Pelvic Pain			Pregnancy Related Pain	
	COPD			Rheumatoid arthritis	
	Congenital defect				
	Depression			Serious injury with permanent damage	
	Diabetes – (adulthood)			Seizures	
	Diabetes (since childhood)			Sinus trouble, chronic	
	Fecal Incontinence			Stroke	
	Glaucoma				
	Gout			Tuberculosis	
	Headaches			Thyroid dysfunction/problems	
	HIV+				
	Hearing loss left ear			Urinary incontinence/complications	
	Hearing loss right ear			Venereal Disease	
	High-blood fat (check one)				
	_____cholesterol			**Date of last:**	
	_____triglycerides			Eye exam: _____	
	Heart disease: Coronary			Colonoscopy: _____	
	Heart disease: Rheumatic			Bone Density: _____	
	Heart problems, Other:			Digital Rectal exam: _____	
	1			Blood work: _____	
	2			Annual exam: _____	
				Mammogram: _____	
				PSA test: _____	

Healthcare Partners
Family Medicine

DISABILITY

A disability is a medical problem that causes long term impairment of your ability to work or function.

Do you have medical disability? YES NO If YES, specify: _____

Specify needs, functional status for disability:
□ Wheelchair □ Require special housing
□ Use crutches □ Sports activity restricted
Do you have loss of or seriously limited function of any of the organs below?
□ eyes □ ears □ bowels □ kidneys □ arms or legs □ other _____

ALLERGIES

An allergy is a skin rash, hives, joint pain or swelling, or fever after exposure to a desensitizing agent.

Do you have any allergies? YES NO Have you undergone allergy tests? YES NO
List items to which you are allergic and indicate reaction:

Medication Allergy	Reaction	Non-medication Allergy	Reaction

MEDICATIONS

Do you take any medicine frequently? YES NO **Please indicate name, strength, frequency, and reason.**

Name of medication	Strength	Frequency	Reason

HOSPITALIZATIONS **YES** **NO**

Reason	Name of Doctor	Year

OPERATIONS **YES** **NO**

If YES, check/list the type/description of operation, date, side of body, and name of doctor who performed the operation.

TYPE OF OPERATION	DATE	BODY SIDE	DOCTOR (if known)
□ Appendectomy			
□ Hysterectomy			
□ Tonsillectomy			
□ Gall Bladder Removal			
Others:			

FAMILY HISTORY

Has any member of your family had any of the following* illnesses? If yes, please place an "X" in the appropriate boxes to identify all illnesses/conditions of your blood relatives.

	Mother	Father	Brother	Sister	Uncle	Aunt	Grandmother	Grandfather
Cancer								
• Type:								
• Type:								
• Type:								
Heart Disease								
High Blood Pressure								
Diabetes								
Liver Disease								
Depression								
Psychiatric Illness								
Other: Please Specify								
Cause of death (if dead)								
Age at death								

Healthcare Partners
Family Medicine

SYSTEMS REVIEW: Please indicate any complications with these body systems:

EYES	**MUSCULOSKELETAL**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
EARS	**NEUROLOGICAL**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
NOSE	**MOUTH/THROAT**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
RESPIRATORY	**GENITOURINARY**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
CARDIOVASCULAR	**HEME/LYMPH**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
GASTROINTESTINAL	**ENDOCRINE**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
BREASTS	**PSYCHIATRY**
□ No current problem **OR**	□ No current problem **OR**
□ Explain complication	□ Explain complication
	INTEGUMENTARY (SKIN)
	□ No current problem **OR**
	□ Explain complication

Healthcare Partners
Family Medicine

WOMEN

Date of last period: _____

NO	YES	
		Have you ever: Had irregular periods?
		Been on birth control pills?
		Been pregnant?
		IF YES, # of pregnancies _____ # of live births _____ # of miscarriages _____ # of still births _____ Weights of live births: _____
		Have you ever had complications in pregnancy?
		Are you taking HRT?
		Are you sexually active?
		Have you ever had excessive pain, bleeding with intercourse?
		* Do you have routine annual breast exams?
		Have you ever had: Hard lumps or cysts in breast?
		Vaginal bleeding after menopause?
		Persistent vaginal itching or dryness?
		Treatment for vaginal infection/discharge?
		Problems with sexual dysfunction?

Age at time of menopause?

CHILDREN ONLY

The following questions pertain specifically to children. This information will help us to ascertain an overall picture of the child's medical problems.

NO	YES	
		Chronic runny nose?
		Chronic red, itchy eyes?
		Purulent drainage from eyes or ears?
		Chronic sneezing spells?
		Purulent episodes of areas of patchy scaly skin?
		Whining episodes?
		Sudden changes in temperament?
		Spells of intense temper with fury?
		Few friends? Problem being shy/timid?
		Writing problems?
		Reading problems?
		Crying spells without reason?
		Speaking problems or stuttering?
		Problems in school?
		Disciplinary problems?
		Problems gaining weight?
		Finicky/picky eating habits?
		Periods of fatigue/lethargy?
		Night sweats?
		Problems with bed wetting?
		Problems with frequent diarrhea or constipation?
		Problems with bowel or urine incontinence?
		Episodes of hyperactivity?
		Sleeping problems/nightmares?
		Problems with sluggishness in the morning?

MEN

NO	YES	In the past year have you had
		Enlarged or infected prostate?
		Pus or drainage from penis?
		Rupture or swelling in groin?
		Nodule in testicle growing larger?
		Problem in sexual function?
		Pain or tenderness in groin?

NOTE: PLEASE BRING COPY OF YOUR MOST RECENT BLOODWORK AND ANCILLARY PERFORMED IN THE LAST YEAR.

I would like to receive “Dr. K’s Health Secrets” newsletter and other informative emails.

Name: _____ Date: _____

Email Address: _____ DOB: _____

Signature: _____