# Optimal Integrative Health Weight Management: Patient Intake

Office Use Only

Chart:

Date:

□ Entered

Entered By:

□ Mr. □ Miss
□ Mrs. □ Ms.
□ Dr.

Last Name: First: Middle:

Marital Status:
□ Single □ Mar □ Div
□ Sep □ Wid □ Part

Gender:
□ M □ F

Birth Date: / /

Age: SSN: E-mail Address:

Address: Address (2):

City: State: Zip:

Phone Number: ( )

Mobile Number: ( )

Fax Number: ( )

Occupation: Employer:

Work Number: ( )

## Contacting You

May we call you?
□ Yes □ No

May we e-mail you?
□ Yes □ No

May we mail you?
□ Yes □ No

How did you hear about Optimal Integrative Health (OIH)?

Where you referred by another physician or physician Office?

## Emergency Contact

Local Friend/Relative: Relationship: Phone Number: ( ) Work Number: ( )

## Insurance Information

Medical insurance policies often deny coverage for weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. If your primary diagnosis is obesity, you may not bill your insurance company for a co-morbid condition. Doing so may result in a charge of fraud against you and/or the physician.

An appropriate receipt of payment will be provided as requested, including a charges and descriptions of the office visit for the different levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies.

Insurance companies may reimburse patients for expenses related to weight management, for instance if co- morbid conditions are also part of the weight management treatment, but reimbursement will not be made from the insurance company to the physician. Again, please understand that Optimal Integrative Health will not present a bill to any insurance company for weight management services or related charges. Optimal Integrative Health will provide what is considered an appropriate receipt, as above described and is not obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard.

If you are covered by MEDICARE INSURANCE you must complete and sign an informed waiver prior to participation in this Weight Management Program.

## Medicare Beneficiary

Are you currently a beneficiary of Medicare? □ Yes □ No

## Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in **Optimal Integrative Healthcare** weight loss program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: Date:

Printed Name: If you are a guardian, what is your relationship to the patient?

# Patient History

| Office Use Only | |
|---|---|
| Chart: | |
| Date: | |
| Revisions: | |

*All questions contained in this history form are strictly confidential and will become part of your medical record on file.*

Last Name: First Name: Middle: Gender: Birth Date: Age:

□ M □ F / /

Primary Physician/Referral: Physician Phone Number:

( )

Optometrist/Ophthalmologist: Ophthalmologist Phone Number:

( )

Weight:

Last Physical: Last EKG: Last Eye Exam:

Goal Weight:

## Health History

**Complete to the best of your knowledge.**

| | Family | Personal | | Family | Personal | | Family | Personal |
|---|---|---|---|---|---|---|---|---|
| Alcohol Abuse | □ | □ | Dizzy Spells | □ | □ | Irregular Pulse | □ | □ |
| Anemia | □ | □ | Drug Abuse | □ | □ | Kidney Disease | □ | □ |
| Arthritis | □ | □ | Eating Disorder | □ | □ | Liver Disease | □ | □ |
| Asthma | □ | □ | Epilepsy | □ | □ | Lung Disease | □ | □ |
| Bleeding Disorder | □ | □ | Fainting Spells | □ | □ | Mental Illness | □ | □ |
| Bloody Stool | □ | □ | Fatigue | □ | □ | Migraines | □ | □ |
| Bronchitis | □ | □ | Frequent Urination | □ | □ | Moodiness | □ | □ |
| Cancer | □ | □ | Gallbladder Disorder | □ | □ | Nervousness | □ | □ |
| Chest Pain | □ | □ | Glaucoma | □ | □ | Obesity | □ | □ |
| Constipation | □ | □ | Headaches | □ | □ | Palpitations | □ | □ |
| Convulsions | □ | □ | Heart Disease | □ | □ | Rashes | □ | □ |
| Depression | □ | □ | High Cholesterol | □ | □ | Shortness of Breath | □ | □ |
| Diabetes | □ | □ | Hypertension | □ | □ | Stroke | □ | □ |
| Diarrhea | □ | □ | Insomnia | □ | □ | Thyroid Disease | □ | □ |

Comments/Other:

## Surgeries & Other Hospitalizations

| Year | Reason / Diagnosis | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Medication Allergies

| Medication Name | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Prescribed Medications & Over-the-Counter drugs, dietary supplements (including vitamins, inhalers, etc) | | |
|---|---|---|
| Medication Name | Strength | Frequency |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Behavior Style** *Please select only one answer.*

| | | |
|---|---|---|
| □ You are always calm and easygoing. | □ You are usually calm and easygoing. | □ You are sometimes calm and easygoing |
| □ You are seldom calm and persistently driving for advancement | □ You are never calm and have overwhelming ambition | □ You are hard-driving and never relax. |

**Health Habits & Personal Safety** *This section is optional. All answers will be kept strictly confidential.*

| | | | | | |
|---|---|---|---|---|---|
| Exercise | □ Sedentary (no exercise) | | | | |
| | □ Mild Exercise (i.e., climbing stairs, walking three blocks, golf) | | | | |
| | □ Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes) | | | | |
| | □ Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more) | | | | |
| Diet | Are you dieting? | | | □ Yes | □ No |
| | If yes, are you on a physician-prescribed medical diet? | | | □ Yes | □ No |
| | How many meals do you eat in an average day? | | | | |
| | Rank your salt intake: | | □ High | □ Medium | □ Low |
| | Rank your fat intake: | | □ High | □ Medium | □ Low |
| Caffeine | Rank your caffeine intake: | □ High | □ Medium | □ Low | □ None |
| | What types of caffeine do you drink? | | □ Coffee | □ Tea | □ Soda |
| | How many cups/cans per day? | | | | |
| Alcohol | Do you drink alcohol? | | | □ Yes | □ No |
| | If yes, what kind? | | □ Beer | □ Liquor | □ Wine |
| | How many drinks per week? | | | | |
| Tobacco | Do you use tobacco? | | | □ Yes | □ No |
| | □ Cigarettes – packs/day: | □ Chew – #/day: | □ Pipe – #/day: | □ Cigars – #/day: | |
| | How many years? | | | | |
| | If you previously used tobacco, what year did you quit? | | | | |
| Drugs | Do you currently use recreational or street drugs? | | | □ Yes | □ No |
| | Have you ever taken street drugs with a needle? | | | □ Yes | □ No |
| Sex | Are you sexually active? | | | □ Yes | □ No |
| | If yes, are you trying for a pregnancy? | | | □ Yes | □ No |
| | If you are not trying for a pregnancy, what contraceptive methods are you using? | | | | |

**Women Only**

| | | |
|---|---|---|
| How old were you at onset of menstruation? | Date of last menstruation? | |
| How often do you get your period (days)? | Number of Pregnancies: | Number of live births: |
| Heavy periods, irregularity, spotting, pain, or discharge? | | □ Yes □ No |
| Are you pregnant, trying for pregnancy, or breast feeding? | | □ Yes □ No |

| Weight History | |
|---|---|
| **1.** | What is the main reason you decided to lose weight? |
| **2.** | When did you begin gaining excess weight (give reasons if known)? |
| **3.** | What do you think is the main cause of your weight problems? |
| **4.** | Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible. |
| **5.** | Is your spouse, fiancé, or partner overweight? |
| **6.** | How often do you dine out? What restaurants do you frequent? What types of food do you eat there? |
| **7.** | List any food allergies: |
| **8.** | What foods do you avoid? |
| **9.** | What foods do you crave? |
| **10.** | Do you awaken hungry during the night? |
| **11.** | What are your worst food habits? |
| **12.** | What are your snack habits? |
| **13.** | Rate your body from 1 to 10. How would you describe your body? |
| **14.** | If you could change one thing about your body, what would it be? |
| **15.** | What do you feel will be your obstacle(s) to successful weight loss? |
| **16.** | What is your typical breakfast? What time? Where? With whom? |
| **17.** | What is your typical lunch? What time? Where? With whom? |
| **18.** | What is your typical dinner? What time? Where? With whom? |
| **19.** | Add any additional comments you think would be helpful to the doctor. |

| Accuracy Agreement | |
|---|---|
| I hereby agree that the information contained in this medical history is accurate to the best of my knowledge. | |
| Signature: | Date: |

***Thank You.***

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.

# Optimal Integrative Health: HIPAA Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

## Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

## Treatment

We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

## Payment

Your protected health information will be used as needed to obtain payment for your health care services.

## Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

## Other Permitted & Required Uses and Disclosures

Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## Your Individual Rights:

1. **You have the right to inspect and receive a copy of your protected health information**. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction on the disclosure of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by an alternative means or at an alternative location**.

4. **You have the right to obtain a paper copy of this notice from us**.

5. **You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information**. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

| OIH Receipt of Notice of Privacy Practices | | Chart: |
|---|---|---|
| Optimal Integrative Health reserves the right to modify the privacy practices outlined in this notice.<br>By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for **Optimal Integrative Health** | | |
| Printed Name: | Patient Signature: | Date: |