Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Thank you for scheduling an appointment with Integrative Family Medicine. In an effort to get to know you better, we have included some forms that we would like you to fill out prior to your first visit. The more honest and complete you can be with your answers, the better we will be able to help you. If at all possible, please fill out these forms before coming for your visit.

If for any reason you need to cancel your appointment, we ask that you give us 24 hours notice. We reserve the right to charge you for your appointment if less than 24 hours notice is given.

## Full payment is due at time of service

**For Medicare and Medicaid Patients Only:**

The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare or Medicaid.

For any questions regarding your appointment or these forms, please call us at (828) 575-9600. We look forward to meeting you.

We would like to take this opportunity to acquaint you with our payment procedure. We intentionally do not file insurance at our clinic. Not filing insurance allows us to focus on you as our #1 priority. As a result of not affiliating with insurance companies we can dramatically reduce fees and pass the savings to you, while increasing your quality of care. It is our goal to exceed expectations of our patients and make financial aspects of your healthcare as convenient and simple as possible.

We will provide you with the paperwork necessary to file insurance on your own, though we cannot guarantee reimbursement.

Privacy and confidentiality of personal health information is important to us. We have HIPAA polices in place to ensure your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves our office either electronically, by fax, or paper record without specific authorization by you. A copy of our policy on privacy is posted at the front desk and you may receive a copy if you would like one.

**I have read and understand the payment procedures and privacy policy of Integrative Family Medicine of Asheville and agree to pay my bill in full at the end of my visit. I also authorize release of any necessary medical records by Integrative Family Medicine of Asheville and to send any referrals on my behalf.**

Signed:_____Date _____

# PLEASE PRINT AND COMPLETE IN FULL

Date_____

Patient's Legal Name:

_____ Nickname_____
Last First M

Sex: Male_____ Female_____ Birthdate_____ Age_____

Social Security Number _____

Is Patient enrolled in Medicare?_____

**If Patient is a minor, Parent/Guardian's:**

#1 Name _____ Relationship _____ Occupation _____

#2 Name _____ Relationship _____ Occupation _____

Patient's Street Address_____ ZipCode_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Name and Relationship of Emergency Contact_____

Phone number of Emergency Contact_____

How did you learn of our office?_____

Reason for visit_____

How will you pay today? Cash_____ Check_____ Credit Card_____

**Payment is due at time of service**

# Health History

**What are your goals for your child's visit today?**

_____
_____
_____
_____
_____

**Prioritize your most important concerns for you child's health today?**

| | Concern | Onset | Frequency | Severity |
|---|---|---|---|---|
| | Ex: Headache | June 2003 | 4 times/wk | mild/mod/severe |
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |

**Has your child seen any other providers for this health concern? If so whom?**

_____

**With whom does you child live? (Including pets)**

| Name | Age | Relationship |
|---|---|---|
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |

**What school does your child attend?_____ What grade?_____**
**Favorite subjects _____**

**What are the most important things to your child?**

_____

**What are the major stressors in your child's life?**

_____

**What does your child do to relax/relieve stress?**

_____

**What hobbies or interests does your child have?**

_____

**What are your child's sources of comfort, nurturing, and connection?**

_____

**How much screen time does your child have in a typical day? (Including TV, Computer, iPad, iPhone, and anything else with a screen) _____**

**How does your child do playing with others in group activities?_____**

**Do you read to your child? Yes___ No___ If yes, how often_____**

**Have you considered encouraging learning a foreign language, music, or other art form? Yes___ No___**
**If yes, please describe_____**

**Does your child have trouble focusing or following guidance?_____**

**Do you have functioning safety plans in the home (smoke detectors, fire escape plan, child-proofed cabinets, toxins out of reach and clearly labeled, safety phone numbers clearly posted?)_____**

## Physical Activity

**What physical activity does your child participate in, and how often?**

_____

**How much time does your child spend out doors each day?_____**

**Exercise Frequency:**
**___ Daily exercise or activity for >60 min**
**___ Daily exercise or activity for 30-60 min**
**___ Daily exercise or activity for 15-30 min**
**___ Daily exercise or activity for <15 min**

## Energy and Sleep

**How is your child's energy level?_____**

**Describe your child's sleep pattern (bed time, hours of sleep/night. Is it continuous? Are there any difficulties with sleep?**

_____

# Nutrition/Digestion

**How many meals does your child generally eat per day? _____**
**Do they skip meals?_____**

**How many servings of fruit per day and what kind?** (Svg: 1small fruit, ½ Cup canned/chopped fruit, ½ Cup dried fruit)
_____

**How many servings of vegetables per day and what kind?** (Svg: ½ Cup raw/cooked, 1 Cup leafy veg.)
_____

**Is your child currently on a special diet? (**Vegetarian, macrobiotic, vegan, raw, other)
_____

**What are your child's favorite foods? _____**

**Food allergies, sensitivities or foods that your child avoids?**
_____

**Does your child consume dairy? If so, how much and what kind** (milk, cheese, yogurt?)
_____

**What amount and kind of carbohydrates does your child eat?** (grains, flour, bread, pasta, starchy vegetables)
_____

**What are your child's sources of protein?_____**

**What type of oil, butter, or spreads is typically used on your child's food?**
_____

**What and how much does your child drink on a typical day?** (water, tea, caffeinated drinks, bottled drinks, soda, etc.)
_____

**How would you describe your child's relationship with food?**
_____

**How often and where does your child eat out?**
_____

**Does you child eat organic food?_____**

**What type and how much does your child consume of sweetened products (natural foods, juices, drinks, sodas, etc)**
_____

**Has your child's weight been stable? Yes ___ No ___**

**Who prepares the meals at home? _____**

**Do you feel knowledgeable about the nutritional needs of your family? Yes ___ No ___**

**Is there a water purifier used at home?_____**

**Does your child feel frequent (circle) : bloating reflux constipation loose stools pain after eating**

**How frequently does your child have a bowel movement?**

**_____**

**Does your child have difficulty digesting (circle): soy wheat dairy nightshades**

**How often does your child eat tuna, yellowfin, or other large fish?_____**

**Please describe your child's typical diet:**

**Breakfast _____**

**Lunch _____**

**Dinner _____**

**Snacks _____**

**Beverages _____**

# Family History

**Who in your immediate family has any of the following?**
**Place appropriate letter in blank and circle type: (F=Father, M=Mother, S=Sister, B=Brother, Son=son, D=daughter)**

Ex: __F__ High Blood Pressure

_____ Alcoholism or Substance Abuse
_____ Anxiety
_____ Anemia (Sickle Cell or Other)
(Other Type_____)
_____ Asthma
_____ Arthritis (Type_____)
_____ Blood clots
_____ Cancer (Type _____)
_____ Chronic Pain
_____ Depression
_____ Diabetes
_____ Digestive (Ulcerative Colitis, Crohns, etc.)
_____Disability (From_____)
_____ Easy Bleeding
_____ Glaucoma
_____ High Blood Pressure
_____ Hay Fever, Allergy, Eczema
_____ Headaches (Migraine, tension, cluster, aneurysm)
_____ Heart Attack, Heart Disease, Heart Failure
_____ Heart Failure
_____ Heart arrhythmia
_____ High Cholesterol
_____Irritable Bowel Syndrome
_____ Kidney Disease
_____ Liver Disease (Hepatitis, etc.)
_____ Lung Disease (Asthma, COPD, emphysema)
_____ Mental Trouble/ psychosis/ nervous breakdown
_____ Seizure, Epilepsy
_____ Stroke
_____ Suicide or attempted suicide
_____ Thyroid Disease (Goiter, high or low thyroid)
_____ Tuberculosis (TB)
_____ Ulcers
_____ Other

# Past Medical History

**Please list any operations/ surgical procedures/ hospitalizations, blood transfusions/major injuries or illnesses (with dates):**

1) Year: _____ Condition _____
2) Year: _____ Condition _____
3) Year: _____ Condition _____
4) Year: _____ Condition _____

**Please list any illnesses that have required your child to miss school, change lifestyle, or that required medication:**

1) Year: _____ Condition _____
2) Year: _____ Condition _____
3) Year: _____ Condition _____
4) Year: _____ Condition _____

**Immunizations/vaccinations: Yes ___ No ___ Partial ___ Delayed Schedule ___ Up to date? Yes ___ No ___**

**Does your child have any Medication, Food, or Environmental allergies?**

**_____ Yes** **_____ No**

↓

**Please list medication or substance and the reaction (what happened when your child took it?):**

| **Medication/Substance** | **Reaction** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Pregnancy with child?**

**Birth: Term_____ Premature_____ Weight_____ Vaginal Delivery_____**

**Caesarian Section_____**

**Were their any problems with pregnancy/labor/delivery Yes___ No ___**

**If yes, please describe _____**

**Breast-fed? Yes ___ No ___ If yes, what age was your child when they were weaned from breast feeding?_____**

**What age did your child begin:**

**Sitting _____Crawling_____ Walking_____ Talking_____**

**Has your child ever been under the care of a mental health professional ___ Yes ___ No**

**If yes, please list condition, date, mental health provider and location of the hospital or treatment facility.**

| | Condition | Date | Provider | Hospital/Treatment facility |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |

# Parental Wellbeing

**What are your methods of coping with stress as a parent? _____**

**What assistance do you have in caring for your child (family support, friends, hired help, parent groups, etc?)**

_____

**Are both parents involved in child care?_____**

**Do you feel that the home is a safe and nurturing environment for your child? If not, what do you feel are the disrupting factors?_____**

**Is there any substance use in the home (tobacco, alcohol, other?) Yes___ No___ If yes, what substance_____**

**Are there guns or weapons in the home? If so, are they safely locked?_____**

**Do you feel that as a parent you are caring for yourself and your relationship with your partner?**

**PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication your child takes or uses**.

| **Name of Medication** (Brand name) and **Strength** | **How was your child told to take this medication?** | **How often does your child take/use this medication?** | **How much does your child take/use for each dose?** | **When did your child begin taking this medication?** | **Condition treated with this medication** | **When did your child stop taking this medication?** | **Why did your child stop taking this medication?** |
|---|---|---|---|---|---|---|---|
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**NONPRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN (Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)**

| **Brand name of Product and list of Ingredients** | **Dosage** | **Amount per dose** | **Frequency** | **When did you begin?** | **Reason for this supplement** | **When did you stop?** | **Why did you stop taking this product?** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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| | | | | | | | |

# Symptom checklist

**(*Please check all symptoms, if any, that your child has experienced during the last 3 months*)**

**General**
___Weight Gain
___Weight Loss
___Heat/Cold Intolerance
___Insomnia
___Fatigue
___Night Sweats
___Motion/Car Sickness
___Other: _____

**Head, Eyes, Ears, Nose**
___Headache
___Migraine
___Ear Pain
___Ringing in Ears
___Changes in Hearing
___Itchy/Watery Eyes
___Dry or Red Eyes
___Eye Pain
___Changes in vision
___Throat pain
___Difficulty swallowing
___Sinus Infection/pain
___Nasal congestion
___Nose bleeds
___Other: _____

**Cardiovascular**
___Congenital Heart Defects
___Heart Murmur
___Easy bruising
___Anemia
___Cold hand/feet
___Other: _____

**Respiratory**
___Difficulty breathing
___Exercise intolerance
___Cough
___Hoarseness of voice
___Snoring
___Asthma or wheezing
___Other: _____

**Gastrointestinal**
___Bloating and Flatulence
___Constipation
___Diarrhea
___Vomiting
___Nausea
___Blood and/or mucus in stool
___Pain during bowel movements
___Anal Fissures
Other: _____

**Eating and Appetite**
___Difficulty gaining weight
___Difficulty losing weight
___Frequent dieting
___Poor appetite
___Always hungry
___Emotional eating
___Cravings
___Binge eating
___Anorexia or bulimia
___Other: _____

**Psychology and Nervous System**
___Anxiety or panic attacks
___Depression
___Difficulty concentrating
___Irritability
___Nightmares
___Unusual Fears
___Difficulty with speech
___Seizures
___Trembling or tremor
___Hyperactivity
___Fainting or feeling lightheaded
___Other: _____

**Musculoskeletal**
___Joint pain, redness, or stiffness
___Neck or back pain
___Foot cramps
___Wrist or hand pain
___Joint deformity
___Muscle pain or cramps
___Muscle weakness
___Restless legs
___Tendonitis
___TMJ/Jaw pain
___Other: _____

**Urinary**
___Acute or Chronic UTI's
___Incontinence or dribbling
___Pain or burning with urination
___Frequent urination
___Blood in urine
___Bedwetting
___Other: _____

**Immune**
___Enlarged lymph nodes
___Painful or tender lymph nodes
___Frequent infections
___Frequent colds or flu
___Slow wound healing
___Other: _____

**Skin and Nails**
___Acne
___Athletes foot
___Jock Itch
___Dandruff
___Dark circles under eyes
___Profuse sweating
___Rashes or hives
___Dry or itchy skin
___Bumps on the back of arms
___Suspicious moles
___Changes in pigment
___Hair loss
___Brittle or breaking nails
___White spots or ridges on nails
___Jaundice
___Other: _____