Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Adult Establish Care Intake Form

Thank you for scheduling an appointment with Integrative Family Medicine. In an effort to get to know you better, we ask that you please fill out the following pages prior to your first visit or arrive 20 minutes prior to your appointment time. The more honest and complete you can be with your answers, the better we will be able to help you.

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 working with you!

Payment Policy

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 health care 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 policies 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.

Signature:_____Date _____

PLEASE PRINT AND COMPLETE IN FULL

Date_____

Patient's Legal Name:

_____ Nickname_____
Last First M

Birthdate_____ Age_____ Social Security Number _____

Sex: Male_____ Female_____ Inter-sex_____

Is Patient enrolled in Medicare or Medicaid?_____

If Patient is a minor, Parent/Guardian's Name_____

Email Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Mailing Address_____ Zip Code_____

Name & 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 this visit?

_____
_____
_____
_____
_____

Prioritize your most important health concerns today?

	Concern	Onset	Frequency	Severity
	Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

With whom do you live? (Including pets)

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Children who don't live with you

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

What are the most important things to you?

_____

What are the major stressors in your life?

_____

What is your occupation? (Current)_____
(Past)_____

What do you do to relax/relieve stress?

_____

What hobbies or interests do you have?

_____

Spiritual beliefs/religious affiliations, past, and present?

_____

What are your sources of Comfort, Nurturing, and Connection?

_____

If you could change one thing in your life, what would it be?

_____

What physical activities do you participate in, and how often?

_____

Nutrition/Digestion

How many meals do you generally eat per day? _____ **Do you 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.)

_____

Are you currently on a special diet? (Vegetarian, macrobiotic, vegan, raw, other)

_____

Food allergies, sensitivities or foods that you avoid?

_____

How much dairy do you consume each day and what kind? (milk, cheese, yogurt)

_____

What amount and kind of carbohydrates do you eat? (grains, flour, bread, pasta, starchy vegetables, sugars/sweeteners)

_____

What are your sources of protein?

_____

What type of oil, butter, or spreads do you add to your food?

_____

What and how much do you drink on a typical day? (water, tea, coffee, caffeinated drinks, bottled drinks, soda, etc.)

_____

How would you describe your relationship with food?

_____

How often and where do you eat out?_____

Do you eat organic food?_____

Who prepares the meals at home? _____

If you were to indulge or treat yourself to a food, what would it be? _____

Do you use a water purifier?_____

Do you feel frequent (circle) : bloating reflux constipation loose stools pain after eating

How frequently do you have a bowel movement? _____

Do you have difficulty digesting (circle): soy wheat dairy nightshades

How often do you eat tuna?_____

Substances

	Amount per Day	Amount per Week	Never Used	Past History of Use
Cigarettes	_____	_____	_____	_____
Cigars/Pipe/Chewing	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Other Drugs/Substances	_____	_____	_____	_____

Have you ever had to cut down on your drinking? ____ Yes ____ No

Do you get annoyed when someone asks about your drinking? ____ Yes ____ No

Do you ever feel guilty about your drinking? ____ Yes ____ No

Do you ever have to make excuses for drinking or for your behavior while drinking?____ Yes ____ No

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

Personal Medical History

If have or have had a condition below, please mark the status with C for Chronic (ongoing), I for intermittent, or R for resolved. If a choice is given, please circle the appropriate one.

_____ Alcoholism or Substance Abuse
_____ Anemia (Sickle Cell or Other)
_____ Anxiety
_____ Arthritis/ Joint Disease
_____ Asthma
_____ Blood Clots/ Phlebitis
_____ Cancer (Type _____)
_____Chemical sensitivity
_____Chronic Pain
_____Depression
_____Diabetes (Type _____)
_____Digestive (Ulcerative Colitis, Crohns, etc.)
_____Easy Bleeding
_____Fatigue
_____ Frequent Sinusitis
_____ Gastroesophageal Reflux (GERD)
_____ Gall Bladder Trouble
_____ Eating Disorder
_____ Hay Fever, Allergy, Eczema
_____ Hearing Loss
_____ Heart Arrhythmia (Type_____)
_____ Heart Attack, Heart Disease, Heart Failure
_____ Heart Murmur
_____ Headaches (Migraines, tension, cluster etc.)
_____ High Blood Pressure
_____ High Cholesterol
_____ History of Infertility
_____ Irritable Bowel Syndrome
_____ Kidney Infection/ Stones
_____ Liver Disease, Hepatitis, etc…

_____ Lung Disease (COPD, Emphysema,etc.)
_____ Nervous Breakdown, Bipolar, or Psychosis
_____ Peptic Ulcer
_____ Pneumonia
_____ Prostate problems
_____ Radiation Treatments
_____ Rheumatic Disease (Type_____)
_____ Rheumatic Fever
_____ Seizures, Epilepsy
_____ Serious Injury or Accident

_____ Sexually Transmitted Disease
(Chlamydia, Warts, Herpes)
(Specify other _____)
_____ Skin Disease (Type_____)
_____ Stroke, TIA, Aneurysm
_____ Suicide Attempt
_____ Thyroid Disease (goiter, nodule, High/Low Thyroid)
_____ Tuberculosis (TB)
_____ Urinary Difficulties (Incontinence, Infections, frequency)
_____Vision Problems
_____ Ear Problems
_____ Constipation
_____ Diarrhea
_____ Blood in Stool
_____Weight Problem (over /under weight)
_____Sleep problems
_____ Sexual, physical, or emotional abuse/trauma
_____ Screening abnormality (Pap, colonoscopy, etc)
_____ Other (Specify) _____

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 _____

Immunizations/vaccinations: _____

_____

When was your last Tetanus Vaccine?_____

Are you allergic to or have you had a "bad reaction" to any medication or other substance?

_____ Yes **_____ No**

↓

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

Medication/Substance	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Energy and Sleep

How is your energy level?_____

Describe your sleep pattern (bed time, hours slept/night, usual wake up time:

_____

Do you need supplements or medication to sleep?	**_____ yes**	**_____ no**
Do you have sleep apnea or do you snore?	**_____ yes**	**_____ no**
Do you worry about sleeping?	**_____ yes**	**_____ no**
Do you need caffeine or other substances to stay alert?	**_____ yes**	**_____ no**

Preventative Screenings (if applicable)

Date of last Colonoscopy_____

Date of last Pap Exam _____ History of abnormal Pap Exam? _____

Date of last Mammogram _____ History of abnormal Mammogram?_____

Date of last Prostate Exam _____ History of abnormal Prostate Exam?_____

Date of last Dexa Scan (Bone Density Test) _____

Gender, Sexual, and Relationship History

Gender Identity: _____Female _____Male Self-defined:_____

How would you describe your sexual orientation? _____

Are you currently in a relationship? _____ yes _____ no Is it monogamous? _____ yes _____ no

Are you happy with your current sex life? _____ yes _____ no
Do you feel safe in your current relationship? _____ yes _____ no
Do you participate in non-vaginal intercourse? _____ yes _____ no
Have you ever had a STD? _____ yes _____ no

Do you have any comments or concerns related to your gender/sexuality?
_____

Have you had any difficult or traumatic experiences related to your sexuality? _____ yes _____ no

Have you received therapy for your relationship or concerns related to your sexuality? _____ yes _____ no

Reproductive Health

Contraceptive History

If applicable, please circle the method/s of contraception you are currently using.

Birth Control Pills **Type** _____ **Total Years of Use** _____
Diaphragm/Cap **Type** _____ **Size**_____
IUD **Type** _____ **Date of Last Change**_____

Other: **Norplant** **Condom** **Foam/Suppository** **Tubal Ligation** **Hysterectomy**
Vasectomy **Herbal** **Rhythm Method** **Abstinence** **Nuvaring**

Unlisted: _____
Experiences with current method: _____

Menstrual and Birth History (if applicable)

Age at 1st menstrual period _____ **First day of most recent menstrual period**_____

Usual Flow: _____ **Heavy** _____ **Moderate** _____ **Light** **Length of period in days** _____

Number of days between periods _____

Do you have (please circle): Painful Periods Missed Periods Spotting Between Periods Vaginal Bleeding

Any unusual discharge, discomfort, infection, or recurring vaginal infections, and if so, what kind?

_____

If you have gone through menopause, have you had any post-menopausal bleeding? _____

Number of: Pregnancies_____ **Live Births**_____ **Abortions**_____ **Miscarriages**_____

Have you experienced complications during pregnancy/delivery/other problems? _____

Prostate and Testicular History (if applicable)

Do you have: _____ **Prostate Problems** _____ **Testicular Cancer**
_____ **Vasectomy** _____ **Premature Ejaculation**
_____ **Erectile Dysfunction** _____ **Trouble conceiving**
_____ **Urethral Discharge** _____ **Other sexual dysfunction**

Do you have incomplete, frequent, difficult or painful urination? _____ **yes** _____ **no**

PRESCRIPTION MEDICATIONS

Please list on the table below ALL prescription medication you take or use.

Name of Medication (Brand name) and **Strength**	**How were you told to take this medication?**	**How often do you take/use this medication?**	**How much do you take/use for each dose?**	**When did you begin taking this medication?**	**Condition treated with this medication**	**When did you stop taking this medication?**	**Why did you stop taking this medication?**

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?