



# MEDICAL HISTORY

Office Use Only

Medical History Completed  
 Completed By: \_\_\_\_\_  
 Date Completed: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

**PAST MEDICAL HISTORY: Have you had any of the following conditions?**

- |                                               |                                                   |                                                       |                                             |
|-----------------------------------------------|---------------------------------------------------|-------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Environmental Allergies  | <input type="checkbox"/> Brain or Nerve Disease       | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Thyroid Disorder     | <input type="checkbox"/> Blood Clots or Phlebitis | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Abnormal Skin Test |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Heart Disease/Problems       | <input type="checkbox"/> Migraine           |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Mental Illness           | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Acid Reflux or Hiatal Hernia | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Kidney Stones            | <input type="checkbox"/> Cancer: _____                | <input type="checkbox"/> Other: _____       |

**LIST ALL CURRENT MEDICATIONS & DOSES (Including birth control, pain meds, sleeping med, non-prescription and vitamins)**

Medication Name	Medication Strength	Medication Dose

**LIST ALL MEDICATION ALLERGIES (Including reaction):** \_\_\_\_\_

**LIST ALL HOSPITALIZATIONS FOR MAJOR ILLNESSES OR SURGERIES:**

Date	Hospitalization and/or Operation

Date	Severe Accidents and/or Injuries

**FAMILY HISTORY: Age at Death / Reason**

Mother \_\_\_\_ / \_\_\_\_      Father \_\_\_\_ / \_\_\_\_      Sibling \_\_\_\_ / \_\_\_\_      Sibling \_\_\_\_ / \_\_\_\_

(Below, please circle any that apply to your family members. Mother = M, Father = F, Sibling = S)

- |                             |                  |                        |                      |                |                    |
|-----------------------------|------------------|------------------------|----------------------|----------------|--------------------|
| M/F/S - Thyroid Disease     | M/F/S - Diabetes | M/F/S - Osteoporosis   | M/F/S - Blood Clots  | M/F/S - Cancer | M/F/S - Ulcers     |
| M/F/S - High Blood Pressure | M/F/S - Stroke   | M/F/S - Mental Illness | M/F/S - Heart Attack | M/F/S - TB     | M/F/S - Alcoholism |

**SOCIAL HISTORY:**

<b>Alcohol use:</b>	<b># of drinks per day:</b>	<b>What age did you start drinking?</b>	<b>Year Quit:</b>
<b>Tobacco use:</b>	<b>Type:</b>	<b># Per day:</b>	<b>What age did you start?</b>
<b>Coffee use:</b>	<b># of drinks per day:</b>	<b>Energy Drink use:</b>	<b># of drinks per day:</b>
			<b>History of Drug abuse: Yes / No</b>

<b>Flu Vaccine</b>	Y N	<b>Date:</b>	<b>Typical breakfast:</b>
<b>Tetanus Booster</b>	Y N	<b>Date:</b>	<b>Typical lunch:</b>
<b>Pneumonia</b>	Y N	<b>Date:</b>	<b>Typical dinner:</b>
<b>Hepatitis B</b>	Y N	<b>Date:</b>	<b>Typical snacks:</b>
<b>Last Colonoscopy</b>	<b>Date:</b>	<b>Result</b>	<b>How often do you exercise?</b>
			<b>What is your workout?</b>

**Patient or Authorized Representative Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



# REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

REVIEW OF SYMPTOMS: (Please check each item "yes" or "no" as they relate to your current health)

<u>CONSTITUTIONAL:</u>	Yes	No	<u>RESPIRATORY:</u>	Yes	No	<u>HEMATOLOGY/LYMPH:</u>	Yes	No
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
			Chills	<input type="checkbox"/>	<input type="checkbox"/>			
<u>EYES:</u>			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<u>MUSCULOSKELETAL:</u>		
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Sputum Production	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>				Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>			Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<u>SKIN:</u>		
<u>EAR, NOSE, THROAT:</u>			Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Change in BM's	<input type="checkbox"/>	<input type="checkbox"/>	Rash/Sores	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Black or bloody BM	<input type="checkbox"/>	<input type="checkbox"/>	<u>NEUROLOGICAL:</u>		
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Strength	<input type="checkbox"/>	<input type="checkbox"/>
						Numbness	<input type="checkbox"/>	<input type="checkbox"/>
<u>CARDIOVASCULAR:</u>			<u>GENITOURINARY:</u>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>	Pain / Burning Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Urinating	<input type="checkbox"/>	<input type="checkbox"/>	<u>FEMALES ONLY:</u>		
Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Flank Pain	<input type="checkbox"/>	<input type="checkbox"/>	Last Mammogram/results: _____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Frequency / Urgency			Last Pap/Results: _____		
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset of periods: _____		
			Rash or Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Last menstrual period: _____		
<u>ENDOCRINE:</u>			Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Menses Cycle Regular?	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	Itching or Odor	<input type="checkbox"/>	<input type="checkbox"/>	Last DEXA Scan/Results: _____		
PMS	<input type="checkbox"/>	<input type="checkbox"/>				Are you on Replacement Hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Irritability/Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<u>PSYCHIATRIC:</u>			Current Birth Control? _____		
Hot flashes/ Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>			
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety and/or Depression	<input type="checkbox"/>	<input type="checkbox"/>	<u>Number of Child Births?</u> _____		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Memory	<input type="checkbox"/>	<input type="checkbox"/>				Heavy Periods	<input type="checkbox"/>	<input type="checkbox"/>
			<u>SEXUAL HEALTH</u>			Painful Cramps	<input type="checkbox"/>	<input type="checkbox"/>
			Loss of Sexual Desire	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge/Itching	<input type="checkbox"/>	<input type="checkbox"/>
			Loss of Sexual Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>
			Pain with Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>
			Inability to Achieve Orgasm	<input type="checkbox"/>	<input type="checkbox"/>			
			Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<u>Cysts in Breasts</u>	<input type="checkbox"/>	<input type="checkbox"/>

Patient or Authorized Representative Signature

Date



# PATIENT REGISTRATION

<b>Office Use Only</b>
<input type="checkbox"/> Registration Completed
Completed By:
Date Completed:

## Patient Information (Please Complete ALL Sections):

Patient Legal Name		Preferred First Name		Date of Birth
Address			City, State, Zip	
Primary Phone		May we leave a confidential message at this #?		Email
		<input type="checkbox"/> YES <input type="checkbox"/> NO		
Assigned Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender Identity/Preferred Pronoun (He/She/They/Other):		Social Security Number:
Pharmacy:		Job/Occupation:		How did you hear about us?
Marital Status:		Emergency Contact Name:		Emergency Contact Phone:
Authorized Representative:		Relationship to Patient:		Authorized Representative Phone:

## Insurance Information (Please Complete ALL Sections):

Primary Health Insurance		Policy #		Group #	
Policy Holder Name			Policy Holder Date of Birth		Sex
					Relationship to Patient
Secondary Health Insurance		Policy #		Group #	
Policy Holder Name			Policy Holder Date of Birth		Sex
					Relationship to Patient
Guarantor's Name (Person responsible for payment)			Address:		DOB:
					Phone:

I am receiving treatment as a result of an accident:  Yes  No  
 If Yes, was it a:  Motor Vehicle Accident  Work Related Accident  Other

Please review and **initial next to each** policy listed below.

**INFORMED CONSENT:** I understand that health care providers cannot guarantee results of treatment. I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. I acknowledge that no guarantee of the outcome of the care I have requested has been made. I have ample opportunity to ask questions, and my questions have been answered to my satisfaction. Chiropractic Care, Physical Therapy, Osteopathy, Massage Therapy, Nutrition Therapy: Though chiropractic, physical therapy, osteopathy, massage therapy and nutrition therapy treatments are usually beneficial and rarely cause any problems, I understand that, like many other forms of health care, there are some risks. These can include, but are not limited to; fractures, disc injuries, cerebral-vascular accidents, dislocations and sprain/strains. These complications are extremely rare occurrences.

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge, that at my request, Complete Care will provide me with a Copy of Complete Care's Notice of Privacy Practices. I understand that Complete Care will use and disclose health information about me. I understand that my health information may include information both created and received by Complete Care, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information. I understand and agree that Complete Care may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

**ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT** I hereby give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I will provide a copy of my current insurance card and I understand I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize Complete Care to release all information necessary to secure payment of benefits. I understand that it is my responsibility to know my insurance policy coverage and benefits and will notify Complete Care of any insurance changes in a timely manner. I understand that my insurance company may have additional stipulations that may affect my coverage and that I am responsible for any amounts not covered. Services rendered may be considered non-covered by my insurance and/or may be subject to deductible in addition to a copay. I understand that I have the right to refuse any service before they are rendered if I think they are non-covered services or not payable by my insurance.



## FINANCIAL POLICIES

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**COPAYMENTS:** I understand that all copays are due at check-in, prior to seeing my provider.

**PRIVATE PAY PRIMARY CARE (SELF PAY):** I understand that if I will be responsible for all charges related to services provided to me by Complete Integrative Care and Complete Care Laboratories. A DEPOSIT of \$125 will be collected at check in, prior to each appointment. The \$125 deposit will be applied toward my balance for services rendered. I understand that I will receive a bill for the remaining balance for services rendered that day.

**ACCOUNT BALANCES:** I understand that if I have a balance on my account I will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. Complete Care will bill my insurance for me if I provide the appropriate billing information. I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter is mailed.

**MANAGED CARE (MEDICAID):** I understand that my insurance coverage is based on funding levels. There are some diagnoses and/or services that are considered non-covered and my insurance will not pay for any additional visits for these conditions or services.

**MEDICARE:** Complete Care is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your annual deductible. If this has not been met, you will be responsible for the deductible and the 20% of allowable charges. By signing this agreement, you authorize any holder of medical or other information regarding the patient names above to release such information to the Social Security Administration effective from this date.

**ANCILLARY SERVICES:** I understand that it is my responsibility to know from whom my insurance company requires me to obtain any labs, x-rays, or any other ancillary services and I will let my providers medical staff know so that they may schedule these services accordingly. If my provider orders any tests, imaging or services not processed here at Complete Care, they will be sent to an outside provider. If you have labs processed at more than one facility, you could receive a statement from both Complete Care and the outside laboratory with any out-of-pocket expense as well as two EOB's (explanation of benefits) from your insurance company. If you have questions regarding charges from one of these services, you will need to contact the outside entity directly.

**CANCELLATION AND NO SHOW POLICY:** I understand that if I fail to notify Complete Care of a cancelation or reschedule at least 1 business day before my scheduled appointment, for any reason, it will be recorded as a "same day" cancellation. If I have more than 3 same-day cancellations per 12-month period I understand that I may be dismissed from care.

**RETURNED CHECKS:** I understand that personal checks returned for non-sufficient funds may be charges a fee of \$25. Balances must be handled by cash, credit card, or money order.

**ON-CALL PROVIDER SERVICES:** Please note that after hours call is available for all primary care urgent needs. **Please be advised prescription refills will not be addressed after hours and that no opioids or benzodiazepines will be prescribed for urgent needs. Please also be advised that if you choose to utilize our after-hours call service and receive care via the phone by the medical provider, there will be a \$50.00 fee billed to your account.** Thank you for your understanding.

***By signing this Financial Policy Notice and Notice of Privacy practices, you, the guarantor, acknowledge that you have read, understand and accept the above policies.***

\_\_\_\_\_  
**Printed Name of Patient or Authorized Representative**

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**



## AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth
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Complete Care has my permission to discuss the information I have marked below with the following people:

- Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_
- Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_
- Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

The following information may be verbally shared with the people listed above:

**(This form does not authorize releasing copies of my records.)**

- Scheduling/Appointment Times and Dates
- Medical information, including my symptoms, diagnosis, medications and treatment plans
- Lab/Imaging/other test results
- Billing and Payment Information
- Other: \_\_\_\_\_
  
- Information is not to be released to anyone.

I understand that I have the right to revoke my permission at any time, and that these permissions remain in effect until the time I revoke in writing.

\_\_\_\_\_  
**Printed Name of Patient or Authorized Representative**

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**