Colorado Osteopathic & Integrative Medicine Associates, PC

Maria T. Gentile, DO, Holly Cauthron, DO and Lauren J. Ramsay PA-C
4901 W. 38th Avenue, Denver, CO 80212
Phone: (303) 781-7862 Fax: (303) 781-7864

Today's Date: _____

Please print the following information:

Name: _____ **Date of Birth: _____-_____-_____**
Address: _____ **Gender: ( ) Male ( ) Female**
_____ **Social Security #: _____**

Home Phone: _____ **Work Phone: _____**
Cell Phone: _____ **Email Address: _____**
Ok to leave message at: ( ) Home ( ) Work ( ) Cell

Religious or Spiritual Affiliation: _____

Occupation: _____ **(If retired or unemployed, please fill out occupation before**
Employer: _____ **retirement or unemployment)**

Insurance Company: _____ **Name on Policy: _____**
Address: _____ **Member ID #: _____**
_____ **Group/Policy Number: _____**
Phone #: _____ **Date of Birth: _____-_____-_____**

Secondary Insurance: _____ **Name on Policy: _____**
Address: _____ **Member ID #: _____**
_____ **Group/Policy Number: _____**
Phone #: _____ **Date of Birth: _____-_____-_____**

Marital Status: S M D W SO
Significant Other/Spouse: _____ Phone: _____

Closest Relative or Emergency Contact: _____
Relationship: _____ Phone: _____

Referred by: _____

Primary Care Provider: _____

We must have your authorization in order to respond to any correspondence from your insurance carrier. Please sign this form so that we may help you obtain reimbursement.

Patient's Name/Insured's Name: _____
Please print clearly

I give permission to this office to release medical information to my health insurance company.

_____ _____ _____
Print Name Signature Date

If you want the doctor to share your medical information with other health providers, please give permission:

_____ _____
Signature Date

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Welcome to our Practice.
To help you get acquainted with the office, we have prepared a few words about our policies and fee schedules. Please read them and provide signatures acknowledging that you understand the guidelines.

Your Appointment:
Your appointment is time set aside for you to see the Doctor/Provider. We have a twenty-four (24) hour cancellation policy. If you cancel an appointment less than 24 hours prior to its scheduled time or miss an appointment, you will be billed **$150** for the missed visit. A message may be left on our answering machine at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the better able we will be to accommodate another patient. We also respect your time and make every effort to be punctual for your appointment.

_____
Signature

Consent for Osteopathic Manipulative Treatment:
I understand the doctor/provider in this office may perform Osteopathic manipulative treatment and I agree to have this treatment whenever necessary.

_____
Signature

Fragrances:
Some of our patients and our doctor are allergic to fragrances such as perfumes, oils and hair sprays. We would appreciate it if you refrain from wearing these to the office.

_____
Signature

Fees & Payment:
- We accept assignment from the following carriers: Aetna, Blue Cross/Blue Shield/Anthem, Cigna, Cofinity, GEHA, Humana, PHCS, Rocky Mountain Health Plan and United Healthcare. Your copay is due on the day of your visit. If we do not accept your insurance, we require payment for services at the time they are provided. In this instance, we supply a standard itemized receipt that you may submit to your insurance company in case you qualify for reimbursement.
- In the case of minors, the parent or guardian who brings the minor in is responsible for the bill. If the parents are divorced or separated and one is responsible for the medical bills, we require payment from the person accompanying the minor at the time of service. This person can then be reimbursed by the responsible party.
- If your check is returned from the bank, we will add a $50.00 “return check” fee to your account.
- If more than one statement needs to be sent to you to collect your portion of the bill, a $5.00 service charge will be added to your bill each time a statement needs to be mailed out.
- If your account needs to be sent to collections for non-payment, any applied discounts will be removed and a 40% service fee will be added to the charges prior to submitting it for collection.

_____
Signature

Children:
Children must be supervised by their caretaker and remain in the treatment room or waiting area only. Please do not allow children to roam about in other rooms.

_____
Signature

Thank you for taking the time to read this policy sheet. If you have any questions about our policies, please ask them now.

We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above policies and agree to them.

_____	_____	_____
Print Name	Signature	Date

HIPAA NOTICE OF PRIVACY PRACTICES

Colorado Osteopathic & Integrative Medicine Associates, PC

4901 W. 38th Avenue
Denver, CO 80212

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND NOW 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 (PHI) to carry out treatment, payment or health care operations (TPO) 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" 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 health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

a. Uses and Disclosures of Protected Health Information
Your PHI may be used and disclosed by your physicians, 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 operation of the physician's practice, and other use required by law.

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

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

b. Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, providing treatment, office operations, billing for services rendered, quality assessment activities, employee review activities, training of medical students or residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students or medical residents that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

c. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. We may use or disclose your PHI in the following situations without your authorization. These situations include, as Required By Law, Public Health and Safety issues as required by law, Reportable Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements such as Product Recalls or Reporting Adverse Reactions to Medications, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Preventing or Reducing a Serious Threat to Anyone's Health or Safety, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Health and Human Services, to investigate or determine our compliance with the legal requirements.

2. YOUR CHOICES

a. 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.

b. You may choose how your information is used in regards to release of your PHI to family and/or friends, to provide disaster relief, or in the provision of mental health care. Under no circumstances will this office ever share your PHI for marketing purposes, fundraising, hospital directories or sell your PHI.

3. YOUR RIGHTS
Following is a statement of your rights with respect to your PHI.

a. You have the right to inspect and/or correct your PHI. You may inspect and/or correct your paper or electronic medical record (if electronic record is available). Under federal law, however, you may not inspect the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. We reserve the right to deny your request for revision, but will provide you with the reason for this denial in writing within 60 days.

b. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we will prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

c. You have the right to a copy your PHI. You may have a copy of your paper or electronic medical record (if electronic record is available). Under federal law, however, you may not copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. We will provide a copy of your PHI, usually within 30 days of your request. We may charge a cost-based fee as designated by the State of Colorado.

d. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who 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. Though every effort will be made to honor your request, 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 your PHI, your PHI will not be restricted. For example, if you are unconscious we may go ahead and share your PHI if we feel it is in your best interest or if it is needed to lessen a serious or imminent threat to health or safety. If the healthcare services are paid for out-of-pocket, you may request that we not share the information with your health insurer. We will agree not to share this information unless it is required by law.

e. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you can ask us to contact you in a specific way at home, at your office, by cell phone, fax, e-mail or mail to your listed address or at an alternate address. We agree to comply with all reasonable requests regarding confidential communication. You agree and understand that e-mail is not secure and that any transmission of your PHI using this method of communication is done at your own risk.

f. You have the right to obtain a paper copy of this privacy notice from us, upon request, even if you have agreed to accept this notice alternatively.

g. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI for up to 6 years prior to the date of your request**.** This excludes any PHI shared for the purposes of TPO. This will be provided one time per year free of charge; subsequent requests within a 12 month period will be charged a cost-based fee.

h. You have the right to choose someone to act on your behalf regarding your health care and PHI. This includes a medical power of attorney or legal guardianship. Legal documentation needs to be provided.

i. You have the right to file a complaint if you believe your privacy rights have been violated. You may complain to our HIPAA Compliance Officer or to the Secretary of Health and Human Services Office for Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. **We will not retaliate against you for filing a complaint.**

4. OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

5. CHANGES TO TERMS OF NOTICE

We reserve the right to change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

This notice was published and becomes effective on or before **September 23, 2013.**

Our HIPAA Compliance Officer: Lauren J. Ramsay, PA-C

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____Signature_____Date_____

PAIN ASSESSMENT and MEDICAL INFORMATION FORM

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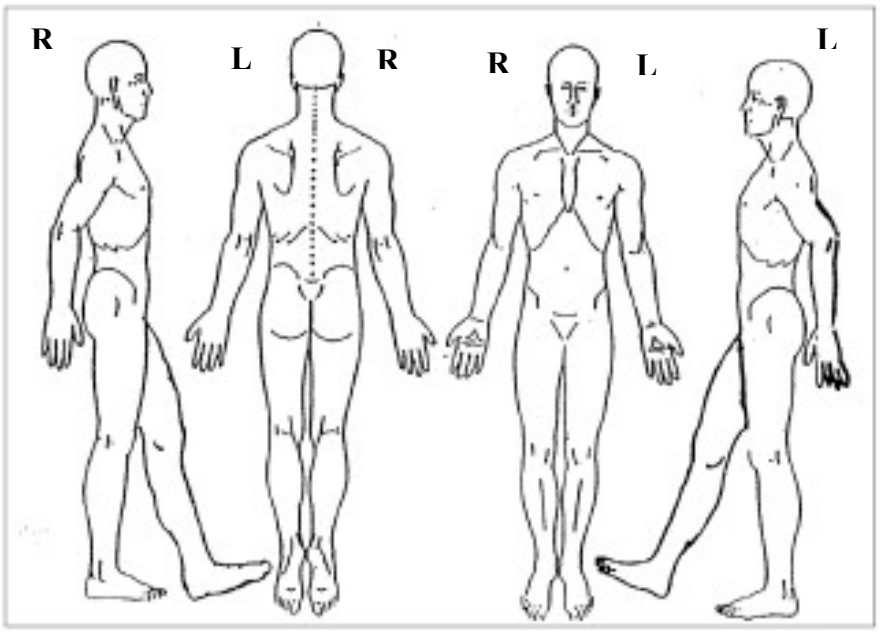
Phone: (303) 781-7862 Fax: (303) 781-7864

PATIENT NAME _____ **DATE** _____

CURRENT PROBLEMS: _____

USE THE DIAGRAM TO SHOW THE LOCATION AND TYPE OF PAIN YOU ARE HAVING:



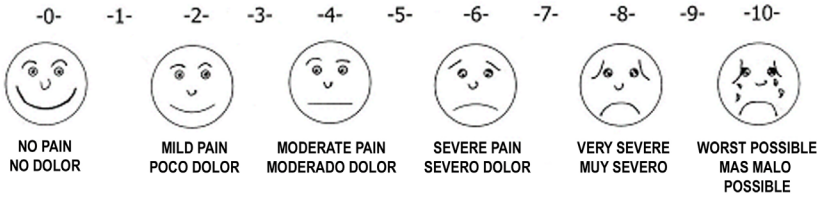
SYMBOLS: ACHE O PAIN X NUMBNESS/TINGLING / / /

BURNING ^^^^ PRESSURE +++ SHOOTING PAIN

LOCATION OF PAIN/PROBLEMS:

- ❑ Head
- ❑ Face
- ❑ Neck
- ❑ Shoulder/Arm /Elbow
- ❑ Hand/Wrist
- ❑ Upper back
- ❑ Mid back
- ❑ Low back
- ❑ Tailbone
- ❑ Ribcage/Chest
- ❑ Hip/Leg/Knee
- ❑ Foot/Ankle
- ❑ Stomach
- ❑ Pelvis
- ❑ Muscle cramps
- ❑ Muscle pain
- ❑ Scoliosis
- ❑ Weakness
- ❑ Limited motion
- ❑ Paralysis

PLEASE RATE YOUR PAIN ON THE 0 TO 10 SCALE BELOW: 0 = No pain and 10 = Intolerable excruciating pain



AVERAGE PAIN LEVEL: _____

AT ITS WORST: _____

Is problem result of a(n) ❑ MVA ❑ Work injury ❑ Fall ❑ Other: _____ Date of Injury? _____

Are you feeling: ❑ Better ❑ Worse ❑ Same **Are you:** ❑ Moving ❑ Functioning any better?

ALLERGIES - medications and others _____

MEDICATIONS OR SUPPLEMENTS: Please list medications/vitamins/herbs, dosages and how they're taken

_____ _____

_____ _____

_____ _____

PREVIOUS HOSPITALIZATIONS:

Reason for Hospitalization	Date	Reason for Hospitalization	Date

SIGNATURE _____

(If patient is a minor, parent must sign.)

Reviewed w/Patient _____

OFFICE USE ONLY

PATIENT NAME _____ **DATE** _____

MEDICAL HISTORY: My Primary Care Physician is: Dr. _____

Problem	Date Diagnosed	Problem	Date Diagnosed

SURGERIES (MM/YY): ❑ Tonsils_____ ❑ Gall Bladder_____ ❑ Appendix_____ ❑ Wisdom Teeth_____
Other (please list) ❑ NONE

Surgery	Date	Surgery	Date

IMMUNIZATION HISTORY

Vaccine	Date					Vaccine	Date	
HepB						**Varicella**		
DTaP						**Flu (last)**		
Hib						**Hep A**		
IPV						**HPV**		
PCV						**Td**		
Rotavirus						**MCV**		
MMR								

Any reactions to vaccinations? (fever, excessive crying, seizures, rash, change in personality) after which vaccine? _____

_____

_____

PREGNANCY and BIRTH HISTORY

Planned/Welcomed ❑ Yes ❑ No
Prenatal Care: ❑ Yes Starting at: _____ weeks ❑ No
During pregnancy did you:

- **Use any:**
  - ❑ Meds _____ ❑ Caffeine _____ ❑ Tobacco _____ ❑ Alcohol _____
  - ❑ Street Drugs _____
- **Have any:** ❑ Stressors _____ ❑ Back Pain ❑ Headaches
  - ❑ Illnesses _____ ❑ Other issues _____ Which trimester? _____

DELIVERY HISTORY

Did your water break on it's own? ❑ Yes ❑ No **# hours in labor?** _____ **Time pushing?** _____
Any medications? ❑ Pitocin ❑ Cervidex ❑ Demerol ❑ Epidural (how far dilated?) _____ ❑ Antibiotics
Presentation: ❑ Vertex (head first) ❑ Breech (legs or feet first) ❑ Transverse (side lying)
Forceps/Vacuum ❑ Yes ❑ No **C-Section** ❑ Yes ❑ No Because: _____
Any complications: _____
Apgar Scores: ____ / ____ **Baby's First Cry:** ❑ Strong ❑ Weak ❑ Absent **Appearance?** ❑ Pink ❑ Pale ❑ Blue
Weight: _____ lbs. _____ oz. **Length:** _____ inches

INFANCY HISTORY

Was/is the baby: ❑ Breast fed ❑ Bottle fed, if so why _____
Length of feedings: _____ mins. **Formula used:** _____
Did you need to change formula? ❑ No ❑ Yes, why: _____
Any problems with: ❑ Latching ❑ Sucking ❑ Spitting up ❑ Vomiting ❑ Colic ❑ Sleeping
Age started on solids? _____ months **Child feeds self?** ❑ Yes ❑ No
What is/was baby's personality (check all that apply)**:** ❑ Calm ❑ Happy ❑ Irritable ❑ Consolable ❑ Active ❑ Sleepy
Was child given belly time as an infant? ❑ Yes ❑ No

SIGNATURE _____ Reviewed w/Patient _____
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DEVELOPMENTAL MILESTONES

Milestones	On Time	Delayed	Milestones	On Time	Delayed
Chest up in prone (2m)	❑	❑	Words have meaning, Mama (9m)	❑	❑
Coos Smiles (2m)	❑	❑	Walk with hands held, pincer grasp (10m)	❑	❑
Up on hands, rolls front/back (4m)	❑	❑	Looks at picture in book (10m)	❑	❑
Reaches, laughs, vocalizes after speaker (4m)	❑	❑	Stands alone (11m)	❑	❑
Rolls back/front, lifts head (5m)	❑	❑	Looks for person named, first word (11m)	❑	❑
Smiles in mirror, object hand to mouth, mimic (5m)	❑	❑	Walks (12m)	❑	❑
Sit supported (6m)	❑	❑	2 words (12m)	❑	❑
Babbles, strangers, looks to floor for fallen object (6m)	❑	❑	Climbs stairs, (16m)	❑	❑
Sits unsupported, support wt, commando (7m)	❑	❑	5-10 words, tower of 3 cubes, fetches (16m)	❑	❑
Bangs/shake toy, feet to mouth, (7m)	❑	❑	Throws Ball (18m)	❑	❑
Gets into sitting position (8m)	❑	❑	10-25 words, Points to self, scribbles (18m)	❑	❑
Peek-a-boo, Dada (8m)	❑	❑	Walks up stairs (20-22m)	❑	❑
Pulls to stand, creeps, grasp with fingertip (9m)	❑	❑	2 word combination (20-22m)	❑	❑

Toilet trained? ❑ Yes ❑ No **Age trained?** _____

GROWTH and DEVELOPMENT

Length/Height Percentile: _____ Weight Percentile: _____

Head Circumference Percentile: _____ BMI Percentile: _____

TRAUMA HISTORY (Major Falls, Accidents, Injuries): ❑NONE

Briefly describe how Injury or Accident occurred	**Injury that resulted**	**Date/Age**

Any emotional traumas? ❑ No ❑ Yes, explain _____

SOCIAL HISTORY:

Water intake: _____ glasses per day **Juice or Pop** (how much) _____ per day

Sugar intake: ❑ Low ❑ Moderate ❑ High **Salt intake:** ❑ Low ❑ Moderate ❑ High

How many daily servings do you have of: Fruit _____ Vegetables _____ Greens _____

Carbohydrates _____ Proteins _____ Fats _____

Are you a: ❑ Meat eater ❑ Vegetarian ❑ Vegan **Do you eat:** ❑ Eggs ❑ Dairy ❑ Fish

DO YOU OR HAVE YOU:

❑ Exercise/play sports? What type? _____ Frequency? _____

❑ Have pets? _____

❑ Live with your: _____

❑ Food preferences: _____

❑ Food restrictions: _____

❑ Food intolerances: _____

❑ Food allergies: _____

❑ Sleep through the night ❑ Have poor sleep Number of hours you sleep nightly _____

❑ Smoke or Chew Tobacco? How much? _____ How many years? _____

❑ Drink Alcohol? ❑ Beer ❑ Wine ❑ Liquor How much/how often? _____

❑ Use(d) drugs? Which ones? _____ How often? _____

I sleep in a ❑ Crib ❑ Soft bed ❑ Firm bed ❑ Other _____ bed

What type of pillow do you use and how many? _____

SIGNATURE _____ Reviewed w/Patient _____

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PATIENT NAME _____ **DATE** _____

The Quality of my Home life is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Miserable

Do you have any stressors at: ❑ Home ❑ School ❑ With friends ❑ Other _____

Explain the stressor (s): _____

My parents are: ❑ Married ❑ Divorced ❑ Separated ❑ Single parent ❑ Remarried

What Grade are you in? _____ **Do you like school?** ❑ Yes ❑ No, why not _____

How are your grades? _____

I socialize with: ❑ Friends ❑ Family ❑ With strangers ❑ On the internet ❑ Through texting

I spend (time) ❑ Doing homework _____ ❑ Texting _____

❑ On the computer _____ ❑ Talking on phone _____

LIST YOUR HOBBIES: _____

HEALTH MAINTENANCE:

My last bloodwork was drawn (date): _____

My last dentist visit was (date): _____

I go to the dentist every: ❑ 6 months ❑ 12 months ❑ 18 months ❑ 24 months

IMAGING STUDIES: I ❑ Have ❑ Have not **had** ❑ X-rays ❑ CT scans ❑ MRI's ❑ EEG's

If yes, list what type, where they were taken and when: _____

FAMILY HISTORY:

Are your parents living? ❑ Yes ❑ No If yes, how old are they? Mother _____ Father _____

If not, how old were they when they passed and what was the cause? Mother _____ Father _____

How many siblings? Brothers _____ Sisters _____

Place in family: Child is # of # siblings

REVIEW OF SYSTEMS

Do you have any of the following symptoms?

CONSTITUTIONAL ❑ Weight changes ❑ Fever ❑ Chills ❑ Malaise ❑ Weakness ❑ Poor sleep ❑ Poor appetite	**GASTROINTESTINAL** ❑ Nausea ❑ Vomiting ❑ Constipation ❑ Diarrhea ❑ Abdominal pain	**SKIN** ❑ Rashes _____ ❑ Lesions _____
Head, Eyes, ENT ❑ Headache ❑ Blurry vision ❑ Earache ❑ Sinus drainage ❑ Sore throat	**GENITOURINARY** ❑ Painful urination ❑ Blood in urine ❑ Frequent urination	**HEMATOLOGY/LYMPHATIC** ❑ Swollen glands ❑ Swollen tonsils ❑ Swelling ❑ Easy bruising
RESPIRATORY ❑ Cough ❑ Trouble breathing	**EXTREMMUSCULOSKELETAL** ❑ Pain _____ ❑ Decreased mobility	**IMMUNOLOGIC/ALLERGY** ❑ Allergies ❑ Chronic infections
CARDIAC ❑ Chest pains ❑ Irregular heartbeats	**NEUROLOGY** ❑ Fussy ❑ Irritable ❑ Seizures	

Is there any other information you would like to include? _____

SIGNATURE _____

(If patient is a minor, parent must sign.)

Reviewed w/Patient _____

OFFICE USE ONLY

PATIENT NAME _____ **DATE** _____

FAMILY/MEDICAL HISTORY: Please answer the following by checking the appropriate box if you or any immediate family members have ever had the following medical problems. No check mark indicates that you have NOT had that particular problem

If you have any of these problems or illnesses: mark the **Self** box with an **"X"**

IF ANY FAMILY MEMBERS HAVE/HAD: (M-Mother, **F**-Father, **S**-Sister, **B**-Brother, **GM**-Grndmothr, **GF**-Grndfather)

	MEDICAL HISTORY	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
GEN	Insomnia			Narcolepsy			Chronic fatigue		
	Poor appetite			Poor circulation					
IMMUN	Allergies			Rheumatoid Arthritis			Gluten sensitivity/intolerance		
	Anaphylaxis			Lupus					
	Hayfever			Sjogren's syndrome			Cancer		
	Chronic infections			HIV positive/AIDS			Type		
HS	Eczema			Acne			Shingles		
	Psoriasis			Melanoma			Baldness		
	Vitiligo								
EYE	Glasses			Glaucoma			Macular degeneration		
	Blindness			Iritis			Cataracts		
HENT	Headaches			Sinus problems			Hearing loss		
	TMJ pain/syndrome			Recurrent sore throat			Ringing in ears		
	Grinding teeth						Meneire's disease		
RES	Asthma			Pheumonia			TB or exposure		
	Emphysema			Sleep apnea			Pulmonary embolus		
CV	Heart Disease/Attack			Pacemaker			High / Low blood pressure		
	Heart valve disorder			Mitral valve prolapse			High cholesterol		
	Atrial fibrillation			Varicose veins			Peripheral artery disease		
	TIA's			DVT's (clots in legs)					
GI	Constipation			Heartburn/GERD			Irritable bowel syndrome		
	Diarrhea			Ulcers or Gastritis			Crohn's dis / Ulcerative colitis		
	Gallbladder dis/stone			Hemorrhoids			Hepatitis / type:		
	Appendicitis			Unable to hold stool					
GU	Painful urination			Chronic bladder infection			Sexually transmitted disease		
	Frequent urination			Unable to hold urine			Which one(s):		
	Urgent urination			Kidney stones					
	Incomplete urination			Bedwetting					
GYN	PMS			Heavy/light periods			Pain between periods		
	Painful periods			Irregular periods					
MS	Joint pain/disease			Muscle Cramps/Aches			Fibromyalgia		
	Back pain – Upper/Low			Scoliosis			Osteoarthritis/ Arthritis		
	Neck pain			Raynaud's disease			Osteoporosis		
	Spinal stenosis			Ankylosing spondylitis			Gout		
NEURO	Multiple sclerosis			Seizures			Alzheimer's disease		
	Stroke			Tremors			Trigeminal neuralgia		
	Fainting			Vertigo or dizziness			Parkinson's disease		
	Spina bifida			Dystonia					
PSYCH	Depression			Bipolar disorder			Abuse survivor		
	Anxiety + / - Panic			Personality disorder			Obsessive compulsive disordr		
	ADD or ADHD			Anorexia or Bulimia			PTSD		
	Alcoholism			Schizophrenia					
END	Diabetes type 1 or 2			Parathyroidism – high/low			Growth disorder		
	Thyroid- high / low			Addison's Disease					
	Obesity			Metabolic syndrome					
HEM	Anemia			Hemochromatosis			Lymphoma		
	Blood disorder			Thrombocytopenia					
	Blood clots/DVT			Leukemia					

SIGNATURE _____

(If patient is a minor, parent must sign.)

Reviewed w/Patient _____

OFFICE USE ONLY

PATIENT NAME _____ **DATE** _____

Any Additional Information:

REMAINDER INTENTIONALLY LEFT BLANK

SIGNATURE _____

(If patient is a minor, parent must sign.)

Reviewed w/Patient _____

OFFICE USE ONLY