Healthcare Partners
A Holistic Medical Practice

PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT NAME: ________________________________ **D.O.B**. ____________ **AGE:** _____

MAILING ADDRESS: ____

CITY: ______________________ **STATE:** _________ **ZIP:** _______ **SEX:** ______

PHONE:_____________________ **CELL PHONE #:** ___________________

SSN: ______________________ **DRIVER'S LICENSE#:** _______________________________

EMAIL ADDRESS: ______________________________________ **FAX:** _________________

ALTERNATE ADDRESS: ____

CITY: _______________________________ **STATE:** ________________ **ZIP:** ___________

EMPLOYER: ____ **PHONE:** ________________

MAILING ADDRESS: (Same as above) ____

CITY: ________________________________ **STATE:** _________________ **ZIP:** __________

WITH WHOM MAY WE SHARE YOUR MEDICAL RECORDS AND/OR NOTIFY IN CASE OF EMERGENCY?

NAME: ___________________________ **RELATION:** _______________ **PHONE:** ___________

MAILING ADDRESS: ____

CITY: ___________________________ **STATE:** __________________ **ZIP:** ________________

PRIMARY INSURANCE: ____

MAILING ADDRESS: ____

CITY: ________________________ **STATE:** ____________________ **ZIP:** _________________

POLICY #: ______________________________________ **GROUP:**___________________________

INSURED NAME: __________________________________ **INSURED D.O.B.:** ________________

SECONDARY INSURANCE: ____

MAILING ADDRESS: _______________________________________ **PHONE:** ________________

CITY: _____________________________ **STATE:** __________________ **ZIP:** ____________

POLICY #: ______________________________________ **GROUP:**___________________________

INSURED NAME: _________________________________ **INSURED D.O.B.:** _________________

** I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS.
** I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO "HEALTHCARE PARTNERS FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE" IN THE EVENT THAT THEY FILE AN INSURANCE CLAIM.
** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID IN FULL OR PARTIALLY PAID BY THE INSURANCE CARRIER.
** I HAVE RECEIVED NOTICE OF THIS ORGANIZATION'S PRIVACY PRACTICES.

SIGNATURE: ____ **DATE**: ________________________

REFERRAL SOURCE: ____

1501 N US Hwy 441 Suite 1704, The Villages, FL 32159
Phone: 352-750-4333 | Fax: 352-750-2023

Records Release Authorization

I, ____________________________________, (print clearly) specifically authorize **HealthCare Partners** to request my protected health information from the specialist or medical practice named below for the purposes of treatment and health care operations.

Description of the information to be used or disclosed (*check all that apply*):
[ ] Any and all Records* [ ] Diagnostic Reports Only [ ] Lab Results Only [ ] Immunizations
[ ] Chart Notes Only [ ] Consultations Only [ ] Other ____________________

*May not include mental health treatment records, psychological services and social services information, including communications made by patient to a social worker or psychologist.
*May not include communicable disease and infection information (which include venereal disease "VD", tuberculosis "TB", Hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").
*May not include alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

Name of the specialist or other medical practice, address, and fax number:
____
____
____

HealthCare Partners shall send information ONLY to the above address and /or fax number. Any disclosure of the patient's protected health information to another address or fax number will require a separate authorization.

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **HealthCare Partners** must receive the revocation in writing with my signature.

This authorization shall expire on _____________________. After this date, **HealthCare Partners** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If date left blank, this is a lifetime authorization for release of information.

I fully understand and accept the terms of this authorization.

__________________________ __________________________
Patient's Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on____________________________________.

Authorization verified by ____ on ______________________.

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HEALTH QUESTIONNAIRE

NOTE: Read carefully – fill in or circle information as completely as possible. The information provided by this questionnaire will become a permanent part of your records at our Center.

Today's Date:

IDENTIFICATION

LAST NAME: FIRST NAME: M.I.:

BIRTHDATE: AGE: GENDER:

ADDRESS:

HEIGHT: FT. IN. WEIGHT: LBS.

NAME & ADDRESS OF YOUR PHYSICIAN (MD, DO, OR DC)

DATE OF LAST CONSULTATION WITH FAMILY PHYSICIAN

DEMOGRAPHIC BACKGROUND

MARITAL STATUS: MARRIED SINGLE DIVORCED: How Long?____ WIDOWED: How Long?___

NUMBER OF MARRIAGES: _______ NUMBER OF CHILDREN? _______

Adult Children's Name	Address	Phone

List additional children's names, addresses and phone at the back or on a separate paper

WORK TYPE:

WORK STATUS: FULLTIME PART TIME RETIRED If retired, how long? _____

ALCOHOL USE: NO YES
If current, how much and how long?
___beers per week/month
____wine glasses per week/month
____ hard liquor per week/month
If you quit drinking, how long ago?

TOBACCO USE: NO YES
If current, how much and how long?
________cigarettes or pack of cigarettes a day/week,
_______ cigars a day/week
_________________ a day/week
If you quit tobacco, how long ago?

RECREATIONAL DRUG USE: NO YES
If yes: Name of drug: ________ how long for __________

EXERCISE: None Light Moderate Strenuous #Times per week: ___

Able to perform activities of daily living? YES NO

CAFFEINE USE: NO YES
If current, how much and how long?
____ cups of coffee per week/month
____ pieces of chocolate per week/month
____ cola cans per week/month

A major life circumstance event?: NO YES
If yes, explain: ____

Depression in the family?: YES NO Self Other:_______________

MAJOR COMPLAINTS AND HOW LONG THEY HAVE BEEN PRESENT, i.e., HEART DISEASE x 10 OR KIDNEY DISEASE x 5 YEARS

____

____

IN YOUR OWN WORDS DESCRIBE YOUR MOST PERSISTENT MEDICAL PROBLEM WITH SYMPTOMS, ITS DURATION AND RESPONSE TO PREVIOUS TREATMENTS: (Can use the back page or separate paper.)

Reviewed by Physician: _________________ (Initials) **Review Date**: _______________ **Patient's Initials: ______**

ILLNESSES AND MEDICAL PROBLEMS

Check problems you have or have had that have been diagnosed or treated by a physician or other health professional

YES	NO	PROBLEM	Last Date Diagnosed	YES	NO	PROBLEM	Last Date Diagnosed
		Alcoholism				Other heart problem (list)	
		Allergies				a.	
		Anemia- sickle cell				b.	
		Anemia – other				Hepatitis	
		Arthritis, degenerative				Herpes (fever blisters, shingles,	
		Osteoporosis / Osteopenia				High blood pressure	
		Asthma				High blood pressure – uncontrolled	
		Bronchitis – chronic				Hypoglycemia – low blood sugar	
		Cancer – breast				Infectious mononucleosis	
		Cancer – cervix				Migraine Headaches	
		Cancer – colon				Obesity – more than 20 lbs or	
		Cancer – lung				Overweight	
		Cancer – uterus				Pelvic Floor Tension Myalgia (check one)	
		Cancer – prostate				____ Chronic Prostatitis	
		Cancer – other				___ Dyspareunia ___ Interstitial Cystitis	
		Chronic Abdominal Pelvic Pain				___ Vaginismus	
		Cirrhosis, liver				Peptic ulcer – gastric, duodenal	
		Colitis, spastic or ulcerative				Phlebitis	
		Congenital defect				Pneumonia	
		Diabetes (since childhood or				Polyps in colon	
		Diabetes – uncontrolled				Pregnancy Related Pain	
		Emphysema				Pre/Post Prostatectomy	
		Fecal Incontinence				Regional ileitis	
		Hay fever				Rheumatic fever	
		Hearing loss left ear				Rheumatoid arthritis	
		Hearing loss right ear				Sinus trouble, chronic	
		High-blood fat (check one)				Serious injury with permanent	
		_____ cholesterol				Stroke	
		_____ triglycerides				Syphilis	
		Heart attack				Thyroid overactive	
		Coronary heart disease				Thyroid under active	
		Rheumatic heart disease				Tension headaches	
		Heart murmur				Tension neck	
		Heart valve problem				Urinary Incontinence	
		Enlargement heart				Voiding Dysfunction	
		Heart rhythm problem				Tuberculosis	

Patient's Initials: ______

DISABILITY
A Disability is medical problem that causes long-term impairment of your ability to work or function
Do you have medical disability? YES___ NO ___
If YES specify
Specify needs, functional status for disability _____ wheel chair _____ require special housing _____ use crutches _____ sports activity restricted If you have loss or seriously limited function of any of the organs below: _____ eyes _____ ears _____ bowels _____ kidneys _____ arms or legs _____ other

ALLERGIES			
An allergy is a skin rash, hives, joint pain or swelling, or fever after exposure to a desensitizing agent			
Do you have any allergies? YES___ NO ___			
Have you undergone allergy tests? YES___ NO ___ If YES, when?			
Check items to which you are allergic to and indicate reaction.			
Allergy	**Reaction**	**Allergy**	**Reaction**
___ aspirin	___________	___ penicillin	___________
___ bee stings	___________	___ poison ivy	___________
___ certain animals	___________	___ pollens, ragweed	___________
___ food allergies	___________	___ tetanus toxoid	___________
a. ___________	___________	___ x-ray media	___________
b. ___________	___________	___ drug allergies	___________
c. ___________	___________	a. ___________	___________
d. ___________	___________	b. ___________	___________
e. ___________	___________	c. ___________	___________
f. ___________	___________	d. ___________	___________
___ dust	___________	e. ___________	___________
___ eggs	___________	f. ___________	___________
___ grasses	___________		
___ mold, fungi			

MEDICATIONS

Do you take any medicine frequently? YES ____ NO ____

Please indicate name, dosage and frequency

___ antacid ________________________________

___ antibiotic ______________________________

___ antihistamine ___________________________

___ allergy shots ___________________________

___ arthritis medicine ______________________

____

___ aspirin ________________________________

___ asthma medicine ______________________

___ barbiturates ___________________________

___ blood thinned ___________________________

___ blood vessel dilator ___________________

___ birth control pill ______________________

___ coronary heart medicine ________________

____

___ cortisone steroid ______________________

___ cough medicine ________________________

___ cholesterol lowering ___________________

___ laxative ______________________________

___ muscle relaxant _______________________

___ nasal spray ___________________________

___ nitroglycerin __________________________

___ nerve medicine

___ pain medicine _________________________

___ penicillin _____________________________

___ potassium supplement __________________

___ rheumatic heart med ___________________

___ sleeping pills _________________________

___ stomach medicine ______________________

___ sulfa

___ tetracycline ___________________________

___ thyroid hormone _______________________

___ tranquilizer ___________________________

Patient's Initials: ______

Have you had any HOSPITALIZATIONS? YES__ NO __

Reason	Name of Doctor	Year

1. ____
2. ____
3. ____
4. ____
5. ____

OPERATIONS

Have you had any OPERATIONS? YES ___ NO ___
If YES, check and date organs of operations.

	Mo Yr		Mo Yr
__Appendix	___________	Hysterectomy	___________
__Back	___________	Joint	___________
__Bone	___________	Kidney	___________
__Brain	___________	Lung	___________
__Breast	___________	Neck	___________
__Colon	___________	Nose	___________
__C-section	___________	Ovary	___________
__Cystoscopy	___________	Prostate	___________
__D & C	___________	Spleen	___________
__Ears	___________	Stomach	___________
__Eyes	___________	Testicles	___________
__Gallbladder	___________	Thyroid	___________
__Heart	___________	Tonsils	___________
__Hemorrhoids	___________	Tubal Ligation	___________
__Hernia	___________	Others	___________

Fill in the history of your blood relatives: children, brothers, sisters, parents, and grand parents.
________ Do not know my family medical history

Relative	Health/Illness	Age	Deceased/Age	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	

Review of Systems: These items concern either existing conditions or symptoms that occurred within the past year. They represent the detail that health professionals seek in evaluating a person's current or potential health problems. Encircle or enter appropriate information. *If you need more room, write additional information at the back of the form.*

Last Exams: Dental:	Eyes:	Gyn (Pap):	Mammogram:

Ancillary Test: Ultrasound:	Bone Density:	CT Scan:	Stress Test:	EKG:	X-Ray:	MRI:

General:

Weight: No Chg	Wgt Gain	Wgt. Loss	Weakness	Fatigue	Fevers	Other

EYES

Pain Redness Tearing Dryness Double Vision Glaucoma Cataracts Glasses

Others: ____

EARS

Itching Vertigo Infections Hearing Abnormal Tinnitus Ear aches Discharge

Other: ____

NOSE Frequent Colds Stuffiness Nose Bleeds Frequent Sinus Discharge Others: _______________

MOUTH/THROAT Gum bleeds Sore Throat Tongue Sores Hoarseness Others: ____________________

CARDIOVASCULAR Chest pain Murmur Dyspnea Orthopnea Rheumatic Fever Hypertension Palpitations Edema PND Heart Problems Claudication Abnormal Tests Other:

RESPIRATORY Cough Sputum Dyspnea Bronchitis Emphysemia TB Bloody Cough Wheezing Asthma Pneumonia Pleurisy Other: ____________

GASTROINTESTINAL Constipation Nausea Black Stool Swallowing Problem Belching/Bloating Indigestion Heartburn Vomiting Diarrhea Flatulence BM habit change Hemorrhoids Appetite Loss Pale Stool Rectal Bleeding Abdominal Pain Vomiting Blood Hepatitis Other: ___________________

INTEGUMENTARY (skin) Rashes Sores Dryness Hair Loss Lumps Itching Color Change

Nail Change Other: ____________________

BREAST Lumps Discharge Discomfort Self Exams Other: _____________________

NEUROLOGICAL Migraines Headaches Weakness Numbness Tingling Temors Fainting Seizures

Vertigo Other: ______________________

PSYCHIATRIC Anxiety Depressed Mood Tension Nervousness Memory Loss Libido Less Bipolar Schizophrenia Other: ____________________________________

GENITOURINARY Urgency Dysuria Incontinence Sores Dysmenorrhea Post Menopause Nocturia Frequency Hesitancy Caliber Dec Dysparunia Amenorrhea OCP Use Hematuria Kidney Stones Vaginal Bleeding Venereal Disease Other: ________________________________

HEME/LYMPH Anemia Bruising Coagulopathy Leukemia Transfusions Enlarge Nodes HIV+ Other: __________________________________

MUSCLE-SKELETAL Joint Pain Stiffness Arthritis Backache Limited ROM Joint Swelling Gout Other: ____

ENDOCRINE Heat Intolerance Cold Intolerance Thyroid Problem Hot Flashes Thirst Polyuria Polyuria Polyphagia Diabetes Sweating Other: ______________________________________

OTHERS Other #1 ____

Other #2 ____

WOMEN		
NO	**YES**	**Have you ever?**
		Had a period?
		Date of last period:
		Had excessive pain, bleeding with period?
		Had bleeding or spotting between periods?
		Had irregular periods?
		Been on birth control pills?
		For how long?
		Been pregnant?
		IF YES: Number of pregnancies:
		Number of live births:
		Weights of live births:
		Number of miscarriages:
		Complications?
		Had excessive pain, bleeding?
		Had hard lumps or cysts in breast?
		* Do you have routine annual breast exams?
		Had vaginal bleeding after menopause?
		Had persistent vaginal itching or dryness?
		Had treatment for vaginal infection/discharge?
		Had problems with sexual dysfunction?
Date of last pelvic exam and PAP:		
Age at time of menopause?		

CHILDREN ONLY The following questions pertain specifically to children. This information will help us to ascertain an overall picture of the child's medical problems.		
NO	**YES**	
		Chronic runny nose?
		Chronic red, itchy eyes?
		Purulent drainage from eyes or ears?
		Chronic sneezing spells?
		Purulent episodes of areas of patchy scaly skin?
		Whining episodes?
		Sudden changes in temperament?
		Spells of intense temper with fury?
		Few friends?
		Problem being shy/timid?
		Writing problems?
		Reading problems?
		Crying spells without reason?
		Speaking problems or stuttering?
		Problems in school?
		Disciplinary problems?
		Problems gaining weight?
		Finicky/picky eating habits?
		Periods of fatigue/lethargy?
		Night sweats?
		Problems with bed wetting?
		Problems with frequent diarrhea or constipation?
		Problems with bowel or urine incontinence?
		Episodes of hyperactivity?
		Sleeping problems/nightmares?
		Problems with sluggishness in the morning?

MEN		
NO	**YES**	In the past year have you had
		Enlarged or infected prostate?
		Pus or drainage from penis?
		Rupture or swelling in groin?
		Nodule in testicle growing larger?
		Problem in sexual function?
		Pain or tenderness in groin?

Patient's Initials: _____