

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Signature: X _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Healthcare PLLC.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X _____
Signature of Patient/Guardian

Date

X _____
Witness (Office Staff)

Date

Name: _____ DOB: _____ Date: _____

Health History
Vitals: Ht: _____ Wt: _____ BP: _____ P: _____ SP02: _____

Medical History:

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Fibromyalgia | |

 Please Describe (if applicable): _____

 Are you currently under drug and/or medical care? Yes No Who is your primary care doctor? _____

 Please all medications: *(Be sure to include dosage and frequency)* _____

 Supplements *(vitamins/herbs/minerals)*: _____

 Allergies: _____

 Surgeries and/or hospitalizations *(type & date)*: _____

Approximate Date of last Flu vaccine: _____

WOMEN ONLY Date of LMP: _____ **Any possibility of pregnancy?** Yes No

 Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings):

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Other _____ | |

Intake of following: Cigarettes _____ packs/day Alcohol _____ drinks/week Caffeine _____ cups/day

 Exercise frequency: Never Daily Weekly _____ Walks Runs Swims _____

 Occupation: _____ Does work mostly involve: Sitting Standing Light Labor Heavy Labor

Reviewed with patient by: _____

 Notes: _____

Review of Systems
Y N Neurological

- Migraines
 Headaches
 Slurring of Speech
 Ringing in Ear(s)
 Pins & Needles- Arms
 Pins & Needles- Legs
 Cold Hands/Feet
 Dizziness

Ear/Nose/Throat

- Altered taste/smell
 Night Blindness
 Sore Throat
 Gingivitis
 Nose Bleeds
 Loss of Smell
 Loss of Taste
 Blurred Vision

Cardiovascular

- Chest Pain
 Heart Palpitations
 Swelling in hands/feet
 Anemia

Respiratory

- Recurrent Respiratory
 Infections
 Allergies
 Asthma
 Chest Congestion
 Wheezing
 Frequent Sneezing
 Shortness of Breath

Y N GI

- Stomach Pains/Cramping
 Constipation
 Reflux /Heartburn
 Bloating
 Gas
 Nausea/Vomiting

Musculoskeletal

- Joint Pain
 Arthritis
 Chronic Pain
 Muscle Aches
 Jaw Problems
 Tension

Skin/Hair/Nails

- Eczema
 Dermatitis
 Excessive Sweating
 Rashes
 Brittle Nails
 Hair Loss
 Easy Bruising
 Increased Bleeding
 Numbness/Tingling

Emotional/Mental

- Depression
 Anxiety
 Nervousness
 Mood Swings
 Irritability
 Memory Loss
 Confusion

Y N Energy

- Fatigue
 Hyperactivity
 Restlessness
 Insomnia
 Decreased Libido
 Stress

Weight

- Decreased Appetite
 Weight Gain
 Inability to Lose Weight
 Food Cravings
 Binge Eating
 Water Retention
 Sudden Weight Loss

Genitourinary

- Uterine Fibroids
 Ovarian Cysts
 Cancer (breast, ovarian,
 prostate, uterine)
 Prostate Problems

Other Symptoms Not Listed: _____
