



PATIENT INFORMATION

Name _____ Date of Birth ____/____/____ Gender M___ F___
 Social Security Number _____ Marital Status S___ M___ D/S___ W___
 Address _____ City _____ State _____ Zip _____
 Primary Phone _____ Secondary Phone _____ Email _____
 Emergency Contact and Phone _____ Employer _____

May we leave a voicemail regarding any test results or appointments? Yes___ No___

Do we have your permission to discuss your treatment with anyone other than yourself? (spouse/child/parent) Yes___ No___

If yes, please list name and relationship _____

Do you have a living will? Yes___ No___ If no, would you like a copy? Yes___ No___

Please list any allergies _____

Pharmacy (and location) _____ Phone _____

Please indicate that you have a Primary Care Physician. Yes___ No___ Name of PCP _____

(The Midway Center Doctors do not provide primary care services.)

INSURANCE INFORMATION *We currently accept **Anthem PPO, Anthem Medicare, and the national Medicare plan***

Insurance Company Name _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber Date of Birth ____/____/____ Subscriber Social Security Number _____

Group # _____ ID # _____

Secondary Insurance? Yes___ No___

Insurance Company Name _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber Date of Birth ____/____/____ Subscriber Social Security Number _____

Group # _____ ID # _____

By signing below I certify that all of the information provided is accurate and up to date to the best of my knowledge. Furthermore, I understand that I am responsible for any remaining balance that my insurance does not cover.

_____/____/____
 Patient Signature Printed Name Today's Date

MEDICAL HISTORY

Surgeries _____

Hospitalizations _____

Major illnesses _____

Major injuries _____

FAMILY HISTORY

Children? Y N Age(s) _____

List all serious conditions below (e.g. heart attacks, strokes, cancer (type), diabetes, other)

Mother | Currently Living? Y N Age _____ Serious Illnesses _____

Father | Currently Living? Y N Age _____ Serious Illnesses _____

Siblings | Serious illnesses _____

PHYSICAL HISTORY

Aerobic activity (e.g. walking - type, daily or weekly amounts) _____

Anaerobic exercise (e.g. weights - type, daily or weekly amounts) _____

Meditation/prayer - frequency and length _____

Alcohol - type, daily & weekly quantities _____

Cigarettes (packs/day) _____ Caffeinated coffee (qty/day) _____ Caffeinated soft drinks (qty/day) _____

Other soft drinks _____ Do you use marijuana or illicit drugs? _____

Eat organic? Y N Vegetarian? Y N Vegan? Y N Non-potato vegetables (qty/day) _____ Fruits (qty/day) _____

EMOTIONAL HISTORY

What is your life vision? What are your passions? _____

What do you want your health for? _____

Adverse childhood experiences? _____

Alcoholic parent? _____ Physically or emotionally abused? _____ Sexually abused? _____

SPIRITUAL HISTORY *Y (Yes) N (No) U (Unsure)*

- ___ Have you had a near-death experience?
- ___ Have you learned to do your best to make the world better and trust the outcome?
- ___ Are you doing the work that you love and making the world better?
- ___ Do you share your feelings?
- ___ Can you find someone to call for a favor?
- ___ Do you belong to a social group or are part of larger community? (i.e. sociable?)
- ___ Do you have the ability to forgive yourself and others?
- ___ Do you experience intimacy, besides sex, in your committed relationships?
- ___ Do you or did you feel close to your parents?
- ___ If you have experienced the loss of a loved one, have you fully grieved that loss?
- ___ Has your experience of pain enabled you to grow spiritually?
- ___ Do you experience unconditional love?
- ___ Have you eliminated judgment and criticism from your words and your life?
- ___ Have you had intuitions, premonitions, or other unusual spiritual experiences?

SYMPTOM HISTORY *Check all that apply.*

- | | | |
|--|--------------------------------|------------------------------------|
| ___ Sensitivity to light | ___ Tingling/odd sensations | ___ Perfume/odor sensitive |
| ___ Brain fog (fuzzy headed) | ___ Headaches | ___ Hearing loss |
| ___ Impaired concentration | ___ Dizziness | ___ Vertigo |
| ___ Forgetful | ___ Visual disturbance | ___ Dry eyes |
| ___ Anxious | ___ Taste disturbance | ___ Smell disturbance |
| ___ Sad | ___ Weight gain | ___ Irritable |
| ___ Panic attacks | ___ Heat intolerance | ___ Cold intolerance |
| ___ Obsessive thoughts | ___ Palpitations | ___ Chest pain |
| ___ Shortness of breath | ___ Wheezing | ___ Fatigue |
| ___ Weight loss | ___ Lethargy | ___ Sleep disturbance |
| ___ Persistent cough | ___ Bloating | ___ Sound sensitivity |
| ___ Bloody bowel movement | ___ Black tarry bowel movement | ___ Constipation |
| ___ Diarrhea | ___ Abdominal cramps | ___ Hemorrhoids |
| ___ Heartburn | ___ Abdominal pain | ___ Nausea |
| ___ Joint pain | ___ Back pain | ___ Swelling |
| ___ Frequent urination | ___ Nighttime urination | ___ Blood in urine |
| ___ Cold feet | ___ Calf pain w/ exercise | ___ Near cell tower |
| ___ Change in moles | ___ Skin problem | ___ Muscles aches |
| ___ Twitches | ___ Tremors | ___ High cholesterol/triglycerides |
| ___ Tick bite | ___ High blood sugar | ___ Low hormones |
| ___ Nightmares | ___ 2 bowel movements daily? | ___ Memory loss |
| ___ Nighttime leg cramps | ___ Restless legs in bed | ___ Mold or toxin exposure |
| ___ Put cell phone to ear | ___ Daytime drowsiness | ___ Dreaming every night? |
| ___ Sleep near wall/outlet | ___ Wireless internet | ___ Arms fall asleep in bed |
| ___ Symptoms only at (or water damage at) home, work or school | | ___ Snore |

EXPOSURE *In the last ten years have you had any of the following? Check all that apply.*

- 'Silver' mercury fillings
- Lived next to major highway
- Exposed to car exhaust or gasoline fumes
- Lived in a city where the air was polluted
- Grew up exposed to car exhaust or gasoline fumes
- Cigarette smoke exposure
- Metal exposure work/hobby
- Grew up in old house
- Eaten fish 3 or more times a week
- Coal dust or mercury exposure
- Eat packaged snack foods
- Eaten tunafish weekly

EXAMS

Year of last colonoscopy _____ Year of last bone density scan _____
Year of last complete physical exam _____ Year of last eye exam _____

WOMEN

Menopausal? Y N Last menstrual period(mo/yr)____/____ Menstrual cramps? Y N Last pap smear (mo/yr)____/____
Last breast imaging (mo/year)____/____ Heavy periods? Y N Low sexual interest? Y N Irregular periods? Y N
Sore breasts? Y N Vaginal dryness? Y N Hot flashes? Y N Night sweats? Y N
Premenstrual irritability, anxiety, sadness, swelling, migraine, or insomnia? Y N

MEN

Date of last prostate blood test (PSA)____/____ PSA level _____
Low sexual interest? Y N Poor sex performance? Y N Loss of drive? Y N Discharge from penis? Y N Curved penis? Y N
Nighttime anxiety? Y N Night sweats? Y N Loss of confidence? Y N Loss of strength? Y N

MAIN CONCERNS

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ / ____ / _____
Patient Name Date

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that MCIH may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

MCIH has a detailed document called the Notice of Privacy Practices. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the Notice before signing this agreement. If I ask, MCIH will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow MCIH to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that MCIH has taken action relying on this consent.

_____ / ____ / _____
Signature (Patient or Legal Custodian/Authorized Representative) Date

_____ / ____ / _____
Relationship to Patient (if signed by another party) Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting MCIH 129 South Winter Street Midway, KY 40347 859-846-4445.

INTEGRATIVE CARE CONSENT FORM

Our office offers nutritional care support through ideas on nutrition and nutrients to support health. Nutrients that are utilized include vitamins, minerals, amino acids, and herbs. These nutrients are not specifically approved by the Food and Drug Administration for any medical condition. As with pharmaceutical treatment, there can be side effects to these approaches and interactions with medicine that could be life threatening, cause morbidity, or lead to hospitalization. By signing this form, the patient is acknowledging that these could occur and pledges to seek immediate care if there is concern, for example if bleeding should occur. The decision to use nutrients is the responsibility of the patient, and the patient is encouraged to educate themselves as much as possible about any nutrients that are mentioned by the practitioner prior to use. I, the undersigned, assume all responsibility for decisions I make regarding use of nutrients, recognizing that a) no claims are made that dietary, nutritional or herbal recommendations can treat or cure any medical condition, b) all recommendations are given for informational purposes only c) there is no implied or stated guarantee of success or effectiveness of any specific dietary nutritional or herbal recommendations d) I am free to act upon or disregard the recommendations of James P. Roach, MD, Courtney Maiden DO, Marie Manheim DNP, APRN, FNP-C, and Lisa Carson, ND as I so choose. I hereby release James P. Roach MD, Courtney Maiden DO, Marie Manheim DNP, APRN, FNP-C, and Lisa Carson, ND from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of the team including any one of these practitioners to participate in a professional relationship with them pursuant to the statement herein. Due to the potential for interaction with medicine, we recommend that you keep other healthcare providers informed of nutrients that you take. While it is our belief that nutrient support is generally beneficial in conjunction with cancer therapies such as chemotherapy or radiation, it is recommended that you discuss this with your oncologist before deciding on use during these, or other, treatments. We strive to make you aware of all options for your care including prescription treatments so please tell us if that is the approach you wish to take and disregard nutrient recommendations.

Our office rarely uses scheduled prescription drugs; please seek another practitioner if you feel you require use of these medicines.

Patient Signature

Printed Name

____/____/_____
Today's Date

Witness Signature



Medical Symptoms Questionnaire (MSQ)

Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

- Point Scale** 0 – *Never or almost never* have the symptom 3 – *Frequently* have it, effect is *not severe*
 1 – *Occasionally* have it, effect is *not severe* 4 – *Frequently* have it, effect is *severe*
 2 – *Occasionally* have it, effect is *severe*

HEAD	_____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	Total _____
EYES	_____ Watery or itchy eyes _____ Swollen, reddened or sticky eyelids _____ Bags or dark circles under eyes _____ Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	Total _____
EARS	_____ Itchy ears _____ Earaches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss	Total _____
NOSE	_____ Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____ Excessive mucus formation	Total _____
MOUTH/THROAT	_____ Chronic coughing _____ Gagging, frequent need to clear throat _____ Sore throat, hoarseness, loss of voice _____ Swollen or discolored tongue, gums, lips _____ Canker sores	Total _____
SKIN	_____ Acne _____ Hives, rashes, dry skin _____ Hair loss _____ Flushing, hot flashes _____ Excessive sweating	Total _____
HEART	_____ Irregular or skipped heartbeat _____ Rapid or pounding heartbeat _____ Chest pain	Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total _____

Grand Total _____



Toxin Exposure Questionnaire

Patient Name _____ Date _____

Please check the best response for each of the following questions. Your provider will discuss your answers with you.

FOOD & WATER	YES	SOMETIMES	IN THE PAST	NO
1. Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you consume canned or farmed fish and seafood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet 'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOME & WORK ENVIRONMENT	YES	SOMETIMES	IN THE PAST	NO
1. Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you live or work in a sealed building with recirculated air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRAVEL & RECREATION	YES	SOMETIMES	IN THE PAST	NO
1. Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you travel by air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you run or bike to work along busy streets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get sick while camping, hiking, or travelling (foreign or domestic)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL & PERSONAL CARE	YES	SOMETIMES	IN THE PAST	NO
1. Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you smoke, or are you often exposed to second-hand smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: For more information on the questions included here, please see the **Toxin Exposure Questionnaire—Bibliography** in IFM's Clinical Practice Toolkit.