



**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? \_\_\_\_\_

**SYMPTOM HISTORY** *Check all that apply.*

- Sensitivity to light or noise
- Nausea
- Dizziness
- Sensitive to odors
- Heartburn
- Vertigo
- Allergies
- Bloating
- Lightheaded/faint
- Sinus problems
- Flatulence/gas
- Weight gain
- Hearing loss
- Black tarry bowel movements
- Binge eating, or craving
- Visual disturbance
- Bloody bowel movement
- Heat intolerance
- Dry eyes, mouth, or skin
- Diarrhea
- Lethargy
- Smell disturbance
- Constipation
- Fatigue
- Taste disturbance
- Hemorrhoids
- Weak or muscle weakness
- Brain fog/fuzzy headed
- Frequent urination
- Daytime drowsiness
- Impaired concentration
- Blood in urine
- Snore, or wake up gasping
- Hyperactive or restless
- Cold feet
- Palpitations
- Learning disability
- Change in moles
- Chest pain
- Forgetful
- Twitches
- High cholesterol
- Memory loss
- Tremors
- High triglycerides
- Irritable
- Tick bite
- Swelling
- Mood swings
- Sleep disturbance
- Calf pain with exercise
- Depressed mood
- Insomnia
- Back pain
- Anxious
- Arms fall asleep in bed
- Muscle aches
- Panic attacks
- Dreaming most nights
- Nighttime urination
- Obsessive thoughts
- Nightmares
- Frequent urination
- Cold intolerance
- Nighttime leg cramps
- Urinary accidents
- Heat intolerance
- Restless legs in bed
- Skin problems
- Shortness of breath
- Put cell phone in ear
- Acne/rosacea
- Weight loss
- Sleep near wall/outlet
- Hives
- Persistent cough
- Turn off WiFi at night?
- Rashes
- Hoarse
- Near cell tower or highway
- Low hormones
- Wheezing
- Tingling/odd sensations
- Hormone imbalance
- Abdominal pain or cramps
- Headaches or migraines
- Frequent illness

## TOXIN EXPOSURE *Y (Yes) N (No) U (Unsure)*

- \_\_\_ Do you drink water from a well, spring, cistern, or plumbing pipes installed before 1986
- \_\_\_ Does your home or workplace contain new construction materials or furniture
- \_\_\_ Does your home or workplace show signs of mold or water damage (cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, crawl space)
- \_\_\_ Are you exposed to toxic substances
- \_\_\_ Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, or scented products
- \_\_\_ Do you live or work near a cell phone tower or high-voltage power lines
- \_\_\_ Do you leave your internet on overnight
- \_\_\_ Do you live or work in an agricultural area or another area exposed to pesticides, etc.
- \_\_\_ Do you frequent parks, golf courses, or other outdoor or recreational areas treated with pesticides, etc
- \_\_\_ Do you run or bike to work along busy streets
- \_\_\_ Are you exposed to toxic chemicals as a result of a hobby
- \_\_\_ Do you have root canals, “silver” fillings, or dental implants
- \_\_\_ Do you have any artificial materials in your body (implants, pins joints, etc.)
- \_\_\_ Do you lead a high-stress lifestyle or have experienced a traumatic event

## 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?

## QUANTUM PHYSICS & THE UNIVERSE *Y (Yes) N (No) U (Unsure)*

- \_\_\_ Do you understand quantum physics – that we are essentially light waves?
- \_\_\_ Do you understand quantum entanglement e.g. mother’s intuition?
- \_\_\_ Do you understand there are 2 trillion galaxies, each with a possible trillion habitable planets?
- \_\_\_ Do you view the Universe as largely a friendly place?
- \_\_\_ Do you believe in one loving, powerful Creator?
- \_\_\_ Do you understand that quantum physics says we are all connected bioenergetically?
- \_\_\_ Do you understand that your heart’s energy field reaches out 15 feet?
- \_\_\_ Do you understand the replicated research that water carries messages and responds to love?
- \_\_\_ Have you or a family member witnessed a UFO?
- \_\_\_ Have you or a family member reported an encounter with an extraterrestrial being?

**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**

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## 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, M.D, Marie Vaubourg-Manheim DNP, Gwen Carnegie NP, Leah Lange NP, and Tonya Moline NP as I so choose. I hereby release James P. Roach MD, Marie Vaubourg-Manheim DNP, Gwen Carnegie NP, Leah Lange NP, and Tonya Moline NP 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

