THE MIDWAY CENTER
FOR INTEGRATIVE HEALTH

NEW PATIENT INTAKE FORM

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** and **Anthem Medicare***

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
_____Sensitive to odors
_____Allergies
_____Sinus problems
_____Hearing loss
_____Visual disturbance
_____Dry eyes
_____Dry mouth
_____Dry skin
_____Smell or taste disturbance
_____Brain fog/fuzzy headed
_____Impaired concentration
_____Hyperactive or restless
_____Learning disability
_____Forgetful
_____Memory loss
_____Irritable
_____Mood swings
_____Depressed mood
_____Anxious
_____Panic attacks
_____Obsessive thoughts
_____Cold intolerance
_____Heat intolerance
_____Shortness of breath
_____Weight loss
_____Persistent cough
_____Hoarse
_____Wheezing

_____Abdominal pain or cramps
_____Nausea
_____Heartburn
_____Bloating
_____Flatulence/gas
_____Black tarry bowel movements
_____Bloody bowel movement
_____Diarrhea
_____Constipation
_____Hemorrhoids
_____Cold feet
_____Change in moles
_____Twitches
_____Tremors
_____Tick bite
_____Sleep disturbance
_____Insomnia
_____Arms fall asleep in bed
_____Dreaming most nights
_____Nightmares
_____Nighttime leg cramps
_____Restless legs in bed
_____Put cell phone in ear
_____Sleep near wall/outlet
_____Turn off WiFi at night?
_____Near cell tower or highway
_____Tingling/odd sensations
_____Headaches
_____Migraines

_____Dizziness
_____Vertigo
_____Lightheaded/faint
_____Weight gain
_____Binge eating, or craving
_____Lethargy
_____Fatigue
_____Weak or muscle weakness
_____Daytime drowsiness
_____Snore, or wake up gasping
_____Palpitations
_____Chest pain
_____High cholesterol
_____High triglycerides
_____Swelling
_____Calf pain with exercise
_____Back pain
_____Muscle aches
_____Nighttime urination
_____Frequent urination
_____Urinary accidents
_____Blood in urine
_____Skin problems
_____Acne/rosacea
_____Hives
_____Rashes
_____Low hormones or hormone imbalance
_____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

THE MIDWAY CENTER
FOR INTEGRATIVE HEALTH

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.

THE MIDWAY CENTER
FOR INTEGRATIVE HEALTH

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

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MEDICATION LIST

Please list medications & supplements you are currently taking.

Patient Name _____				Date of Birth ___/___/_____	
Appointment Date					
Rx or Supplement	Dose	Dose	Dose	Dose	Dose