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 list medications & supplements you are currently taking on the medication list

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
___Brain fog (fuzzy headed)
___Impaired concentration
___Forgetful
___Anxious
___Sad
___Panic attacks
___Obsessive thoughts
___Shortness of breath
___Weight loss
___Persistent cough
___Bloody bowel movement
___Diarrhea
___Heartburn
___Joint pain
___Frequent urination
___Cold feet
___Change in moles
___Twitches
___Tick bite
___Nightmares
___Nighttime leg cramps
___Put cell phone to ear
___Sleep near wall/outlet
___Tingling/odd sensations
___Headaches
___Dizziness
___Visual disturbance
___Taste disturbance
___Weight gain
___Heat intolerance
___Palpitations
___Wheezing
___Lethargy
___Bloating
___Black tarry bowel movement
___Abdominal cramps
___Abdominal pain
___Back pain
___Nighttime urination
___Calf pain w/ exercise
___Skin problem
___Tremors
___High blood sugar
___2 bowel movements daily?
___Restless legs in bed
___Daytime drowsiness
___Wireless internet
___Perfume/odor sensitive
___Hearing loss
___Vertigo
___Dry eyes
___Smell disturbance
___Irritable
___Cold intolerance
___Chest pain
___Fatigue
___Sleep disturbance
___Sound sensitivity
___Constipation
___Hemorrhoids
___Nausea
___Swelling
___Blood in urine
___Near cell tower
___Muscles aches
___High cholesterol/triglycerides
___Low hormones
___Memory loss
___Mold or toxin exposure
___Dreaming every night?
___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 complete physical exam_____

Year of last bone density scan_____

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, Courtney Maiden D.O., Marie Vaubobourg-Manheim D.N.P., and Lisa Carson, N.D. as I so choose. I hereby release James P. Roach M.D., Courney Maiden D.O., Marie Vaubobourg-Manheim D.N.P., and Lisa Carson, N.D. 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

MEDICATION LIST

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

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

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
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** 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
(Does not include near or far-sightedness)

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
_____ Bloated 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 _____

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

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?	☐	☐	☐	☐
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)	☐	☐	☐	☐
3. Do you consume canned or farmed fish and seafood?	☐	☐	☐	☐
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	☐	☐	☐	☐
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐	☐	☐
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)?	☐	☐	☐	☐

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?	☐	☐	☐	☐
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐	☐	☐
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.)?	☐	☐	☐	☐
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?	☐	☐	☐	☐
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐	☐	☐
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	☐	☐	☐	☐
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	☐	☐	☐	☐
10. Do you live or work in a sealed building with recirculated air?	☐	☐	☐	☐

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?	☐	☐	☐	☐
2. Do you travel by air?	☐	☐	☐	☐
3. Do you run or bike to work along busy streets?	☐	☐	☐	☐
4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?	☐	☐	☐	☐
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	☐	☐	☐	☐

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?	☐	☐	☐	☐
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	☐	☐	☐	☐
3. Do you smoke, or are you often exposed to second-hand smoke?	☐	☐	☐	☐
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	☐	☐	☐	☐
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	☐	☐	☐	☐
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐	☐	☐
7. Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies?	☐	☐	☐	☐
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	☐	☐	☐	☐
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	☐	☐	☐	☐

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

IFM®