**INTEGRATED MEDICINE OF IOWA**

**Intake Form**

375 Collins Rd. NE Ste #22 Cedar Rapids IA 52402

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ ☐Male ☐Female Home phone_____ Cell Phone _____

Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____Family Medical Doctor_____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____

Parent or Guardian Date

**Responsible Party**

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

**Do you have any Medical insurance?** ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS**
**AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE**
**AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay INTEGRATED MEDICINE OF IOWA as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

# Health History

Patient Name: _____DOB: _____Date:_____

## Chief Complaint: _____

## History of Present illness:

**Location**: _____ (Where is the pain/problem?)

**Quality:** _____ (Example: normal vs abnormal color, activity, etc..)

**Severity:** _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

**Duration:** _____ (How long have you had this pain/ problem? When did it start?)

**Timing**: _____ (Does the pain/problem occur at a specific time?)

**Context:** _____ (Where were you at the onset of this pain/problem?)

**Associated Signs/Symptoms** _____ (What other associated problems have you been having?)

**Modifying Factors** _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

## Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles…… NO YES Anemia……..NO YES Back Trouble……NO YES Hepatitis……NO YES
Mumps……. NO YES Bladder Infection…….NO YES High Blood Pressure……NO YES Ulcer……NO YES
Chicken Pox…… NO YES Epilepsy……NO YES Low Blood Pressure…….NO YES Kidney Disease……NO YES
Whooping Cough… NO YES Migraine Headaches. NO YES Hemorrhoids……NO YES Thyroid Disease……..NO YES
Scarlet Fever……. NO YES Tuberculosis……..NO YES Date of Last Chest X-Ray_____ Bleeding Tendency…….NO YES
Diphtheria…… NO YES Diabetes……..NO YES Asthma……..NO YES Any Other Disease…….NO YES
Smallpox……. NO YES Cancer……NO YES Hives of Eczema…….. NO YES (Please List):
Pneumonia……. NO YES Polio……NO YES AIDS & HIV……NO YES
Rheumatic Fever… NO YES Glaucoma……NO YES Infectious Mono……NO YES _____
Arthritis……. NO YES Hernia……NO YES Bronchitis……..NO YES
Venereal Disease… NO YES Blood or Plasma Transfusion……..NO YES Mitral Valve Prolapse…. NO YES Stroke……NO YES _____

| **Previous Hospitalizations/Surgeries/Serious Illnesses** | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medication:** (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

## Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

**CLINICIAN SIGNATURE:** _____ **DATE REVIEWED:**_____

**PATIENT NAME:** _____ **DATE:**_____

**Family Medical History:**

| | Age | Disease | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

**Eyes/Ears/Nose/Throat/Respiratory**

| | |
|---|---|
| Asthma | 1 2 3 4 5 |
| Stuffy Nose | 1 2 3 4 5 |
| Hay Fever | 1 2 3 4 5 |
| Sore throat | 1 2 3 4 5 |
| Chronic Cough | 1 2 3 4 5 |
| Chest Congestion | 1 2 3 4 5 |
| Frequent Sneezing | 1 2 3 4 5 |
| Itchy/Watery Eyes | 1 2 3 4 5 |
| Drainage | 1 2 3 4 5 |
| Earache or Ear Infection | 1 2 3 4 5 |
| Itching | 1 2 3 4 5 |
| Hoarseness | 1 2 3 4 5 |
| Shortness of Breath | 1 2 3 4 5 |
| Wheezing | 1 2 3 4 5 |

**Muscular/Skeletal**

| | |
|---|---|
| Muscle Aches | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 |
| Knee Pain | 1 2 3 4 5 |
| Ankle/Foot Pain | 1 2 3 4 5 |
| Pain b/t shoulder blades | 1 2 3 4 5 |

**Neurological**

| | |
|---|---|
| Headaches | 1 2 3 4 5 |
| Migraines | 1 2 3 4 5 |
| Dizziness | 1 2 3 4 5 |
| Numbness | 1 2 3 4 5 |
| Tingling | 1 2 3 4 5 |
| Pins/needles in hands or feet | 1 2 3 4 5 |

**General**

| | |
|---|---|
| Fatigue | 1 2 3 4 5 |
| Malaise | 1 2 3 4 5 |
| Weakness, tiredness | 1 2 3 4 5 |
| Lightheadedness | 1 2 3 4 5 |
| Irritability | 1 2 3 4 5 |
| Constipation | 1 2 3 4 5 |
| Diarrhea | 1 2 3 4 5 |
| Feeling foggy | 1 2 3 4 5 |
| Forgetfulness | 1 2 3 4 5 |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date