



HEALTH HISTORY QUESTIONNAIRE

Center for Family Wellness

Helping You Create Health, Wellness & Well-Being

Name (Last, First, MI):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:			
City:		State:	Zip:
Phone: (H):		(W):	(C):
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Spouse / Significant Other:			# Children:
E-Mail Address:			
Employer:			
Job Description:			

FOR MINOR CHILD		
Parent/Guardian:		
Relationship to Child:		
Address (if different than above):		
Phone: (H):	(W):	(C):

REFERRAL SOURCE
Who told you about our office?

OFFICE POLICIES

PAYMENT OF BILLS

100% of services are due and payable as services are rendered. We expect you to honor the financial arrangements you make with our office. If you find that you cannot fulfill these agreements, advise our financial manager immediately so new arrangements can be made. *A patient may not have a personal balance of more than \$50.00 without having a Payment Plan Agreement.*

Any account balance over 60 days is subject to interest charges of 1 ½% per month. Failure to make payment of an over due account or to otherwise communicate within 60 days will cause the account to be placed in collections. If you are sent to collections, you will be charged a \$50.00 administrative fee to cover the costs of pre-collections letters and phone calls. You are responsible for any collections costs and reasonable attorney fees allowed by law. There is a charge for all checks returned for insufficient funds. The actual charge is the maximum allowable by current law.

APPOINTMENTS

If you are unable to keep your appointment, we ask that you give us 24 hour notice for cancellations, so the time may be made available to others who may need the service. If you miss an appointment with prior notice, you will incur a charge of 60% of your appointment fee. If you cancel with less than 24 hours notice, you will incur a charge of 30% of your appointment fee. In true emergencies, neither charge will apply. What is considered an emergency is left to our discretion.

CONSENT TO TREAT MINOR

I hereby authorize the staff and health care providers at the Center for Family Wellness to administer health care as they deem necessary to my

_____ (relationship of child) _____ (name of minor)

Signature of Parent/Legal Guardian _____ Date: _____

POLICY AGREEMENT

I have read all the information stated above and I am in agreement with the policies as presented.

Signature _____ Date: _____

**Privacy Notice
for Use and/or Disclosure of
Protected Health Information**

We will use and disclose elements of your Protected Health Information (PHI) in the following ways:

With Your Signed Authorization:

- Treatment (treatment procedures within the Center for Family Wellness, PA as well as sending notes and information to other health care providers to assist in treatment and/or consultations).
- Payment (send personal information, diagnosis codes, procedure codes, office notes).
- Health Care Operations (filing, scanning documents, quality control)
- Communications to you via fax, phone, recorded telephone message, voice mail and e-mail (we have no control over who has access to these permanent communications and cannot guarantee that only you would receive the information)

Without Your Signed Authorization:

- When release is required by law, including in judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue and other donations organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences (or a positive indication).

Other Uses

All other uses and disclosures by us will require us to obtain from you a written authorization specific to the granted use.

Your Rights

You have the following rights concerning your PHI:

Restrictions: To request restricted access to all or part of your PHI, you must make the request in writing and indicate specific restrictions and to whom access is restricted and for what period of time. We are not required to grant your request.

Confidential Communications: To receive correspondence of confidential information by alternate means or location, you must indicate method and location by written request.

Access: To inspect or receive copies of your PHI, please make a request in writing. Usually we can make copies within three business days.

Amendments: To request changes be made to your PHI, you must make the request in writing and indicate specific details. We are not required to grant your request.

Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request, please make the request in writing.

This Notice: To get updates or reissue of this notice, please request.

Complaints: You may complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. Register a complaint with us by mail to Privacy Officer. The law forbids us from taking retaliatory action against you if you complain.

Our Duties

We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Patient Name (printed)

Date

Patient Signature

Authorized Provider Representative

**Consent for Disclosure of Health Information
Additions / Exceptions List**

Exclusions

I want to exclude the disclosure of any of my health information to the following providers, individuals, organizations, hospitals, and/or insurance companies:

Patient name printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.

Additions

I want to allow the disclosure of any of my health information to the following providers, individuals, organizations, hospitals, and/or insurance companies:

Patient name printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.

Name (<i>Last, First, MI</i>):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Referring Physician:		Date of Last Physical:

CHIEF COMPLAINT		
What is your problem?		
When did this episode begin? How did it begin?		
Have you had similar problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes, since	If so describe:
Is the problem getting worse?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Is the problem relieved by rest?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
It interferes with	<input type="checkbox"/> Bending <input type="checkbox"/> Carrying groceries <input type="checkbox"/> Changing positions from seated to standing <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Concentration <input type="checkbox"/> Driving <input type="checkbox"/> Extended computer use <input type="checkbox"/> Feeding <input type="checkbox"/> Household chores <input type="checkbox"/> Lifting <input type="checkbox"/> Reading <input type="checkbox"/> Self care <input type="checkbox"/> Sleep <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Work: <input type="checkbox"/> Other:	
List previous diagnoses		
List previous treatment		
I am interested in	<input type="checkbox"/> Acute Care <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Wellness	
I would be willing to participate in	<input type="checkbox"/> Exercise Program <input type="checkbox"/> Stress Reduction <input type="checkbox"/> Ergonomic Education <input type="checkbox"/> Gain Weight <input type="checkbox"/> Lose Weight (how to sit, stand, & work properly) <input type="checkbox"/> Stop Smoking <input type="checkbox"/> Change Diet <input type="checkbox"/> Follow nutritional/herbal <input type="checkbox"/> Make other lifestyle changes that are necessary recommendations	
Your Physicians	Family Physician Internist Ob/Gyn Other	

PERSONAL HEALTH HISTORY		
Childhood Illnesses	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations	<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chickenpox <input type="checkbox"/> MMR (<i>Measles, Mumps, Rubella</i>)	
List any medical problems that other doctors have diagnosed:		
Surgeries		
Year	Reason	Hospital
Other Hospitalizations		
Year	Reason	Hospital

Sex	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not, list contraceptive or barrier method used:	
	Any discomfort with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY					
Age		Significant Health Problems	Age		Significant Health Problems
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH	
Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WOMEN ONLY	
Age at onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies _____, Number of live births _____	
Are you pregnant or breast feeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last PAP and rectal exam:	

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of times _____	
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel any burning discharge from the penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam: _____	

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

VITALS			
B/P:	Pulse:	Temp:	Height: Weight:
Supine B/P:	Standing B/P:	30' Recover B/P:	