Patient Information

General Information

AdvantAge Integrative Medicine

Name:
Date of Birth:
Social Security Number: *Used as your unique medical record identifier*
Height:
Weight:
Mobile Telephone:
Email Address: May we use your email to send medical related messages? ☐ Yes ☐ No *Your email will never be sold to a third party. You will only receive newsletters or other emails specific to IMC or its related clinics.*
Mailing Address:
Street Address (if different):
City / State:
Zip Code:

Emergency Contact:
Relationship:
Telephone:

Your Occupation:
Your Employer:

Current Physicians / Health Providers:

How did you hear about us? How did you hear about Health and Wellness Coaching?

Policies

Notice of Insurance, Billing & Missed Appointment Policies

Please read and initial each section – thank you!

Advantage Integrative Medicine does not participate in insurance plans, nor submit claims, nor complete paperwork for insurance claims. Payment is due in full at the time of service with cash, check or major credit card. Our returned check charge is $25.

Initials _____

Due to government regulations we are NOT able to provide services to **Medicaid beneficiaries** for any service that would normally be covered by Medicaid. We are allowed to provide services that are clearly not covered by Medicaid, such as low dose allergy injections or specialized IV therapies. Please contact us if you have questions about whether a specific therapy is allowed.

We gladly accept cancellations up to 24 hours in advance without penalty. Missed appointments without advance notice will be charged 50% of the scheduled visit fee and future appointments will require a credit card number in advance.

Initials _____

We will provide you with an invoice with diagnosis codes (ICD10) listed that you may submit to your insurance company for reimbursement. Some insurance companies will honor invoices for services provided and some will not. We do not have control over these practices.

If your insurance company incorrectly submits claims to other offices that Dr. Rollins works in, then those claims and any payments will be returned.

Initials _____

Medicare beneficiaries only:

Dr. Rollins *does not see Medicare beneficiaries*. I understand that Medicare beneficiaries need to see one of our Providers that have "opted out" of Medicare.

Initials _____

I, or my legal representative, agree not to submit a claim, nor ask the practitioner to submit a claim, to Medicare or items or services, even if such items or services are otherwise covered by Medicare.

Initials _____

By signing below, I confirm that I am not a Medicare or Medicaid beneficiary.

Signature _____ Date _____

I have read the above policy information and by signing below agree to the terms outlined.

Signature _____ Date _____

Health Questionnaire

Please fill out to the best of your knowledge

Check if *you* have ever had:

- o Allergies
- o Arthritis
- o Asthma
- o Autoimmune disease
- o Blood clots
- o Bowel disease
- o Cancer
- o Diabetes
- o Fibromyalgia
- o Frequent infections
- o Heart disease
- o High blood pressure
- o Kidney disease
- o Liver disease
- o Lung disease
- o Mental illness
- o Neurologic disease
- o Skin disorder
- o Stroke
- o Thinning of bones
- o Ulcers
- o Urinary infections

Check if *you* have ever had (WOMEN only):

- o Abnormal mammogram
- o Abnormal pap smear
- o Abnormal vaginal bleeding
- o Breast cancer
- o Cervical cancer
- o Fibrocystic breasts
- o Ovarian cysts
- o Uterine cancer
- o Uterine growths
- o Uterine infections

Check if *you* have ever had (MEN only):

- o Enlarged prostate
- o Mumps
- o Prostate cancer
- o Prostate infections
- o Testicle infection
- o Vasectomy

Other / Explain above: _____

_____

_____

Surgeries (dates): _____

_____

Allergies: _____

_____

Current Medications (dose/frequency) and Supplements including marijuana/CBD products:

_____

_____

_____

Health Questionnaire

Continued...

Hormones taken in PAST (dates): _____

_____

_____

Menstrual History (WOMEN only):

Age of first menses: _____ Date of last menses: _____

History of abnormal menses? _____ Explain: _____

_____

Date of last pap smear: _____ Date of last mammogram: _____

Family History

(list any conditions from category list on prior page – for deceased family members give cause of death and approximate age)

Father: _____

Mother: _____

Paternal GF: _____

Paternal GM:_____

Maternal GF: _____

Maternal GM: _____

Siblings: _____

Social History

Do you smoke or chew tobacco?_____ How much per day? _____

Do you drink alcohol? _____ How much per day? _____

Do you use any other drugs? _____ How much per day? _____

Do you exercise regularly? _____ How much per week? _____

How would you describe your stress level? Low / Moderate / High

Are you married? _____ Do you have children? _____ How Many? _____

Any toxic exposures, e.g. metals, pestisides, etc? _____

What foreign countries have you visited and when? _____

What are your HEALTH GOALS?

_____

_____

_____

Health and Wellness Coaching

Why are you interested in Health Coaching? What do you want to gain from coaching?

_____

_____

What is the best way for me to coach you most effectively and hold you accountable?

_____

_____

Name 3 strengths of yours.

_____

_____

What gives you a sense of purpose in life? What activities have meaning for you?

_____

_____

Personal

What motivates you to become healthier?

_____

_____

What accomplishments or events must occur within your lifetime to consider your life satisfying and well-lived?

_____

_____

What is missing in your life, the presence of which would make your life more fulfilling?

_____

_____

What is your spiritual belief system? How to you use these beliefs for support and encouragement?

_____

_____

What two steps could you take immediately that would make the greatest difference in your current situation?

_____

_____

How does your job match up with your sense of purpose?

_____

_____

In what ways does your job affect your level of stress and your health?

_____

_____

Health and Wellness

Please describe your lifestyle and what you do to be healthy and well.

_____

_____

Describe any health challenges you may have.

_____

_____

What do you do when you feel really stressed? How do you manage and reduce stress?

_____

_____

How often do you currently exercise? What types of physical activity do you do?

_____

_____

Describe your diet. What types of foods do you eat? How often do you eat out?

_____

_____

How many hours of sleep do you get each night? How do you feel upon waking and throughout the day?

_____

_____

What is your daily water intake? Do you carry a water bottle with you?

_____

Readiness to Change

Readiness Score:

1 = Haven't thought about changing this
2 = Have given change some thought
3 = Have started preparing to change (looked up information, talked to others about it, etc.)
4 = Am already taking action steps to change
5 = Have already made changes and want help maintaining my progress

To What Degree Do You Experience the Following?

List lifestyle behaviors you'd like to change	1	2	3	4	5

What else should I know about your health, wellness and life goals?

_____

_____