BALANCED LIFE AND HEALTH

Physicians Plaza
100 Covey Dr., #204
Franklin, TN 37067
615-972-9700

New Patient Information: Please complete the entire form.

Last Name: ______________________________ First Name: _________________________ MI ___

DOB _____/ ______/ _____ Gender M/F

Street Address ____

City ___________________________________ State ____________ Zip _________________________

Home Phone ______________________ Work ________________________ Cell _________________

E-mail ____

Indicate how you would prefer to be contacted _________________ Best time to contact _________

How did you hear about *Balanced Life and Health* ~ whom may we thank?

____

Employer ____

Marital Status S M W D Spouses Name ____

Emergency Contact ____ Phone ______________________

Preferred Pharmacy _____________________________________ Phone _____________________________

Primary Care Physician ___________________________________ Phone _____________________________

Acknowledgement

The above information is true to the best of my knowledge. I understand that I am financially responsible for all professional services.

Patient Signature ____ Date _______________________

BALANCED LIFE AND HEALTH

New Patient Health Questionnaire

Name ____ DOB ____/ ____/ ____ Gender M/F

Reason for today's visit ____

____

Three (3) to five (5) goals pertaining to your health that you would like to see improved over the next year ____

____

____

____

____

Please list all previous or current medical problems	**Surgeries (including year)**
____	____
____	____
____	____
____	____
____	____
____	____
____	____
____	____

For women: # pregnancies _____ # live births_____ Date of last pap smear: __________________________ Date of last mammogram: _________________________ Have you had a Bone Density Test? ___ When ________ Have you had a Colonoscopy? _____ When _________ Have you had a Pneumovax? _____ When __________	**For men**: Date of last prostate exam/PSA ____________________ Have you had a Colonoscopy? _____ When _________ Have you had a Pneumovax? _____ When __________

Please list all **MEDICATIONS** you are currently taking:

Prescription	Dose	How Often?	How Long?	Side Effects?

Please list all **SUPPLEMENTS** you are currently taking:

Supplement	Dose/Strength	How Often?	How Long?

Medication Allergies: ____
____
____
____

Personal History:

Do you smoke? Y/N **Have you smoked in the past?** Y/N If yes, # packs/day _____ #yrs. __________

Do you drink alcohol? Y/N If yes, average # of drinks per week __________________________________

Do you take recreational drugs? Y/N If yes, please specify ______________________________________

Family History: Please list any significant medical problems, or cause of death if deceased.

Mother ____ living/deceased

Father ____ living/deceased

Siblings:

____ living/deceased

____ living/deceased

____ living/deceased

____ living/deceased

In the past month, I have experienced (circle all that apply):

Fevers	Weight loss	Weight gain	Excessive fatigue	Headaches
Visual changes	Hearing loss	Ear ringing	Runny nose/sore throat	Shortness of breath
Cough	Wheezing	Snoring	Chest pain	Palpitations
Swelling	Abdominal pain	Nausea	Diarrhea	Bloody stool
Black stool	Trouble urinating	Blood in urine	Frequent urination	Excessive thirst
Cold intolerance	Joint pain	Joint swelling	Muscle pain	Weakness
Dizziness	Tremor	Easy bruising	Bleeding problems	Sadness
Crying	Panic attacks	Poor concentration	Hair loss	Memory loss
Sleeplessness	Mood swings	Low sex drive	Limited energy	

Name: ____ Date: _____________________

Circle any of the following you have experienced in the past 6 months.

MUSCULOSKELETAL	NEUROPATHY
Low Back Pain	Nervous
Neck Pain	Paralysis
Joint Pain/Stiffness	Numbness
Difficulty Chewing	Dizziness
Pain btwn the Shoulders	Forgetfulness
Arm pain	Confusion/Depression
Walking Problems	Fainting
Clicking Jaw	Convulsions
General Stiffness	Cold/Tingling in Extremities

Is there pain when you cough or sneeze? ____ Yes ____ No If **Yes**, where? ________________________________

____

Is there pain when you go from sitting to standing? ____ Yes ____ No If **Yes**, where? ________________________

____

Do you get headaches? ____ Yes ____ No If **Yes**, circle all that apply:

Tension Sinus Migraines Throb Other

Circle any function(s) below that aggravates, or are aggravated by your condition:

Walking Running Step Climbing Driving Recreation Other

____

* *

ORAL HEALTH

Check any of the following you have experienced in the past 6 months

_____ Earaches
_____ Headaches
_____ Cracked Teeth
_____ Receding Gums
_____ Bleeding Gums
_____ Gum Infections
_____ Yeast Infections
_____ Crowded Teeth
_____ TMJ

Date of Last Dental Exam ____/ ____/ ____

No# of amalgam (silver) fillings? __________

No# of Root Canals? ___________________

Nutrition: (Please track three (3) days of food and fluid (ozs) intake)

Breakfast	**Lunch**	**Dinner**
Fluids:		
Snacks:		

Breakfast	**Lunch**	**Dinner**
Fluids:		
Snacks:		

Breakfast	**Lunch**	**Dinner**
Fluids::		
Snacks:		

LIFESTYLE CHANGES

GOOD FOR ME (makes me feel more alive, healthy, and happy)	**BAD FOR ME** (drains me, takes away my energy, and health)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

BALANCED LIFE AND HEALTH

HIPAA (Health Insurance Privacy & Accountability Act)

Due to HIPAA regulations, we must ask you the following questions regarding your Protected Health Information.

What phone number is best to call with test results and appointment reminders?

Home: ( ) ____

Cell: ( ) ____

Does our office have permission to (please circle one):

1. Leave voice mail on your home phone? Yes No
2. Leave voice mail on your cell phone? Yes No
3. Leave a message or try to contact you at your place of employment? Yes No
4. Discuss your medical results or conditions with any member of your household (including confidential information) Yes No
5. Would you like a paper copy of our HIPAA privacy notice? Yes No
   * Please note that a copy of our privacy notice is on display on our website www.balancedlifeandhealth.com

____

Please print name

____ ____________________________

Signature **Date**

BALANCED LIFE AND HEALTH

E-MAIL Communication Policy

- Patient and physician will sign e-mail informed consent
- A copy of signed e-mail inform consent will be given to the patient and a copy will be placed in the patient's medical record
- Balanced Life and Health will have security systems in place, e.g. password-protected screen saver of all desktop workstations in every location that e-mail can be viewed
- Messages will contain the physician's full name, contact information and reminders about security and the importance of alternative forms of communications for emergencies
- E-mails are not forwarded to any third party without the patient's expressed permission
- Patient's e-mail accounts are never used in any marketing schemes, nor shared with physician's family members
- Any patient's identifiable information, social security numbers or birthdates are only sent via encryption if the communication is wireless
- Physician will always double-check all "TO" fields before sending any e-mail message
- E-mail backups are performed weekly onto long-term storage
- E-mail communications will include the following statements
    1. "E-mail communication cannot be guaranteed to be entirely secure or confidential and that it is not always read in a short time period after it is sent, so that the telephone should be used for more 'urgent' communications."
    2. "Confidential: This message contains information that may be privileged or confidential and is the property of Balanced Life and Health. It is intended only for the person to whom it is addressed. If you are not the intended recipient, you are not authorized to read, print, retain, copy, disseminate, distribute or use this message or any part thereof. If you receive this message in error, please notify the sender immediately and delete all copies of this message."
- Automatic reply will be configured to acknowledge receipt of messages
- A new message will be sent to inform patient of completion of request
- A mailing list of patients will be maintained, but group mailings will not be sent where recipients are visible to each other. Blind copy features in software will be used.
- Messages will avoid anger, sarcasm, harsh criticism, and libelous references to third parties

____ ______________________

Patient Signature **Date**

____ ______________________

Physician Signature **Date**