Instructions: Answer all items to the best of your knowledge. For additional space, use "Additional Comments" on page 4.

General Information

Name ____________________

Street Address ____________________

City ____________________ State _______ Zip ____________________

Telephone (day) _____________ (evening) ________________ (cell)__________________

Email Address ____________________

Birth Date ______________ Age _________ Social Security Number ___________________

Primary Physician's Name: ________________________________ Phone__________________

Emergency Contact Name: ________ _______________________ Phone__________________

Reason for Today's Visit: ____________________

Please list all prescription medications and dosages: ____________________

____

____

Medical History

In general how would you describe your health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Do you have any heart conditions? [ ] Yes [ ] No
Describe: ____________________

Have you ever had high blood pressure? [ ] Yes [ ] No

Have you ever had your cholesterol level tested? [ ] Yes [ ] No
If Yes, what were the results? ____________________

Do you have asthma, chronic bronchitis, emphysema, or other lung condition? [ ] Yes [ ] No
Describe: ____________________

Do you have diabetes? [ ] Yes [ ] No If Yes, specify Type: [ ] Type 1 [ ] Type 2
If so, how is it controlled? ____________________

Do you have any stomach/bowel disorders? [ ] Yes [ ] No
Please explain: ____________________

Have you ever had cancer? [ ] Yes [ ] No
If so, what type and when was it diagnosed? ____________________

Please describe any other significant medical history:____________________

____

____

Medical History (Continued)

Please list allergies to Medications (including the reaction): ____

____

Please list any surgeries you have had and when: ____

____

Family History: Please indicate which immediate family members (grandparents, parents, siblings, and/or children) **have had any one of the following health issues** (Specify **G**, **P**, **S** and/or **C**):

Cancer		Other Family Health History			
Breast		High Blood Pressure		Mental Illness	
Ovarian		Heart Attack		Obesity	
Cervical		Stroke		Other	
Uterine		Diabetes			
Colon		Osteoporosis			
Other		Alzheimer's			

Social History

Marital Status: Married [ ] Single [ ] Coupled [ ] Divorced [ ] Widowed [ ]

Sexual Orientation: Heterosexual [ ] Homosexual [ ] Bisexual [ ]

Are you currently sexually active? Yes [ ] No [ ] # of sexual partners (lifetime) ________

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes [ ] No [ ] Within the past 12 months: Yes [ ] No [ ]

Have you ever been forced to have sexual activities you did not want to have?

Yes [ ] No [ ] Within the past 12 months Yes [ ] No [ ]

Do you wear your seat belt when you drive? Yes [ ] No [ ] Sometimes [ ]

Do you have at least one smoke detector in your home? Yes [ ] No [ ]

What is your occupation? ____

Company name and nature of business ____

Health History

How many caffeine-containing drinks do you consume each day (including coffee, tea and soda)? ______

Do you currently smoke? Yes [ ] No [ ] If Yes, how long does a pack last? __________
Number of years smoking? _________ Number of years since quitting? __________

How many alcoholic drinks do you consume in a week? ____________
What type of alcohol do you drink? (beer, wine, liquor) ____________

Do you use any recreational drugs? Yes [ ] No [ ]
If so, please list: ____

Are you currently involved in an exercise program? Yes [ ] No [ ]
How many hours a week on average do you:
Perform vigorous exercise (e.g. brisk walking, jogging, biking, aerobics classes) ______
Perform strength training (e.g. weight machines or free weights) ______
Perform stretching exercise (e.g. yoga, tai chi, ballet, general stretches) ______
How long have you been doing your current routine? _______________

How many meals a day do you usually eat? ____________ snacks? _________
How many meals do you usually eat away from home each day? ___________

What is your current weight? _______ What is your current height? _________
Have you recently gained or lost weight? Gained [ ] Lost [ ] Stayed the same [ ]

	Never	Hardly Ever	Some times	Nearly Always	Always
Do you feel in control of your eating habits?	[ ]	[ ]	[ ]	[ ]	[ ]
Do you feel in control of your lifestyle?	[ ]	[ ]	[ ]	[ ]	[ ]
Do you find yourself obsessing about food, weight, body image?	[ ]	[ ]	[ ]	[ ]	[ ]
Do you have periods of low energy, mood swings, and irritability?	[ ]	[ ]	[ ]	[ ]	[ ]
Are you satisfied with the quality and quantity of your sleep?	[ ]	[ ]	[ ]	[ ]	[ ]

Please list any herbals, supplements or vitamins you are taking:____

____

____

Do you have a spiritual/ religious practice? Please describe: ____________________________________

____

____

Women Only

Last Menstrual Period ______________
Have you ever been pregnant? Yes [ ] No [ ]
If so, age of first delivery _______ # of pregnancies _____ # of deliveries _____
Method of Contraception ______________
Last pap: ______________
Have you ever had an abnormal pap? Yes [ ] No [ ]
Have you had a mammogram? Yes [ ] No [ ]
If so, when _________ Was it normal Yes [ ] No [ ]
Have you ever had a bone-density test (Dexa scan)? Yes [ ] No [ ]
If so, when _________ Was it normal [ ] borderline [ ] low [ ]

Men Only

Have you had a Prostate test (PSA) done?,,,,,,,,,,,,,,,,,,,,,,,,,,,,, Yes [ ] No [ ]
What were the results? ________________

Summary

What is your primary goal for our work together? ____

____

____

____

____

____

Additional Comments

____

____

____

____

____

____

Signature _____________________________________ Date ___________________________

Medicine In Balance

940 Town Center Drive
Suite F-90
Langhorne, PA 19047
(215) 741-1600

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information.

Uses and Disclosure Relating to Treatment, Payment, and Healthcare Operations

- We will use your personal health information to perform medical treatment and conduct normal healthcare office operations.
- Other uses and disclosure, as deemed necessary by your medical provider, not requiring your written authorization:
    - To public health agencies requiring disclosure of patient health information as it relates to matters of public health risk
    - Lawsuits and similar proceedings in response to court ordered subpoena
    - If required to do so by a law enforcement official
    - If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities
    - To federal officials for intelligence and national security activities authorized by law
    - To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official
    - For Workers Compensation and similar programs

Uses and disclosure requiring your authorization

- Upon receiving your written request, we will print your chart or situationally specific items from your chart as directed by your provider and send it to another medical professional. This will only be performed in the office.

Your rights regarding your personal health information

- Your right to request restrictions on certain uses and disclosures
    - If in fact you request restrictions on the use and disclosure of your information as outlined above, please state them in writing. An authorizing signature is required.
    - If the restriction requested inhibits the practice's ability to give the best care, you will be notified by mail within 30 days from the date of receipt of your request that it can not be honored.
    - Appeals to restriction requests not honored must be in writing and received within 30 days of the date of the letter sent denying the request.
    - All appeals will be reviewed and answered within 30 days.
    - Until a restriction request is approved, the practice will conduct business without incident to a pending restriction request.
    - All requests are singular in nature. Multiple requests must be submitted separately.
- Your right to request restrictions on communication from our office
    - Please refer to the "Patient Provider Contact Form"
- Your right to access and copies of your medical and billing records
    - Copies of medical and billing records will be available 10-14 days after the request is received in writing to the medical records clerk.
    - There is a $25.00 charge for in-house copying, payable upon receipt.
    - Only you or an authorized representative can pick up copies of your medical and/or billing records.

    - Records can be mailed or faxed upon your written request and the practice's receipt of the $25.00 in-house copying charge.
    - Your right to copies of medical and billing records is superceded and denied in the following situations:
        - ♣ It will endanger your life or the life of another individual named in the record
        - ♣ The records reference another individual and disclosing such information would violate their privacy.
        - ♣ Psychotherapy notes can not be viewed or copied
        - ♣ Information collected and compiled in anticipation of legal action or preceding
        - ♣ Confidential information related to lab tests under CLIA
        - ♣ Information requested by a legal guardian or representative on your behalf that the medical professionals feel may cause harm to you or someone else.
- Your right to request an amendment of your medical information
    - If you believe your medical information is incorrect or incomplete, you may submit a written request for the information to be amended.
- Your right to a copy of this notice
    - **Please print out and retain a copy of this form as well as the Patient Provider Contact Form for your records**
- Your right to file a complaint
    - If you feel that your rights regarding privacy have at all been violated, you may file a formal written complaint with the Office Manager.
    - You will not be penalized for filing a complaint.
    - Complaints may also be submitted to the Secretary of the Department of Health and Human Services.
- Your right to provide an authorization for other uses and disclosure
    - Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
- Your right to receive an accounting of all disclosures outside of the practice setting and with other individuals
    - You may request to view a list of all disclosures.

The practice reserves the right to make changes to this notice at any time and which will become effective on the date of the change, superceding all previous versions. The version number and date of update are located on the bottom left hand corner of each page.

If you have any questions regarding this notice or our health information privacy policies, please contact us at (215) 741-1600.

Patient Signature____

Signature of Parent or Guardian_________________________________Date__________________________

Patient-Provider Contact Agreement

Federal law now requires very strict limitations on the manner in which providers can contact their patients in order to maintain confidentiality. Although the theory is a good one, it can make life complicated for all of us. We would therefore like to ask you now for permission to contact you in the best way for your lifestyle. Listed below are several options; please mark the ones you agree to. You may change these at any time by contacting us in writing.

Phone contact:
Preferred number to use: Home ___ Work ___ Cell____ (please check **one**)

Home phone:
You may not leave messages on my machine about lab and test results, but you may leave appt reminders. ______
You may leave any kind of message on my machine, including lab and test results. _______
You may not leave messages with family members. _____
You may leave messages with family members. ______
I do not have an answering machine. ______

Work phone:
You may not leave messages concerning lab and test results, but you may leave appt reminders. ______
You may leave messages on my voicemail, including lab and test results. _____
You can not contact me at my work. ______ Not applicable to me. ________

Cell phone:
You may not leave messages on my voicemail about lab and test results, but you may leave appt reminders. ____
You may leave any kind of message on my voicemail, including lab and test results. ____
I do not have access to voicemail on my cell phone. ____

Email Agreement

Email is an easy and convenient way for us to communicate. For instance, it allows you to contact us during a time we are not open. However, please remember that it does have drawbacks. For instance, not all providers are in the office each day and you won't know if we are on vacation. We will make every effort to check email frequently, but **it could be several days before you hear from us.** Email is **never**, **ever** appropriate for emergencies or urgent questions. It is also not appropriate for any questions that require a good deal of discussion; it is not a substitute for an office visit. Email does not know how to do exams---if you think you need to be seen, please call to make an appointment. Also remember that email is not confidential; our system has no additional security beyond your usual email provider's system. You therefore may not want to discuss some sensitive issues via email. Any emails to our office become a part of your medical record.
Guidelines for use: Please send your message to the appropriate provider (eg. drwarner@medicineinbalance.com). If you aren't sure or you need to contact the front desk, please send your message to info@medicineinbalance.com.

I do want to use email to communicate with this office. _____
I do not want to use email to communicate with this office. ____

Your Signature: ________________________________ Today's Date: ________________________________