HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather, etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. – 9 a.m. ❑ 9 a.m. – 11 a.m. ❑ 11 a.m. – 1 p.m.
❑ 1 p.m. – 3 p.m. ❑ 3 p.m. – 5 p.m. ❑ 5 p.m. – 7 p.m.
❑ 7 p.m. – 9 p.m. ❑ 9 p.m. – 11 p.m. ❑ 11 p.m. – 1 a.m.
❑ 1 a.m. – 3 a.m. ❑ 3 a.m. – 5 a.m. ❑ 5 a.m. – 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. – 9 a.m. ❑ 9 a.m. – 11 a.m. ❑ 11 a.m. – 1 p.m.
❑ 1 p.m. – 3 p.m. ❑ 3 p.m. – 5 p.m. ❑ 5 p.m. – 7 p.m.
❑ 7 p.m. – 9 p.m. ❑ 9 p.m. – 11 p.m. ❑ 11 p.m. – 1 a.m.
❑ 1 a.m. – 3 a.m. ❑ 3 a.m. – 5 a.m. ❑ 5 a.m. – 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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BETWEEN THE BRIDGES HEALING CENTER, LLC
45 TETON LANE, MANKATO, MN 56001
FINANCIAL POLICY

Insurance
If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract.

Minors
The adult who signs as the "Financially Responsible Party" is responsible for payment of services rendered. Our office will not become involved in disputes between divorced parents.

Payments Due at Time of Service
YOUR PAYMENT WILL BE DUE AT THE TIME OF SERVICE.
As a **new** patient, this office requires a $50 pre-payment at the time of scheduling. This is non-refundable if you miss your appointment without notice to this office. If you keep your appointment, the $50 payment will be applied towards your account for any out of pocket responsibility.

Returned checks will result in a fee of **$25.00 per check**.
All unpaid personal balances are subject to **monthly service fee of $5.00** or 6% of the balance.
Any accounts sent to collections will be assessed an **additional $40 fee**.

As an established patient, if you miss 3 appointments without notification to this office, it is grounds for dismissal from this practice. We also reserve the right to discharge any patient who is verbally abusive or threatening to any staff member.

Credit Card on File
This office does request a credit card be provided and kept on file for phone services, supplement orders by mail and any other services that may not be paid at the time of service. You will always be notified of the use of this card for payments that are charged.

Medicare Patients
I am aware that services received at Between the Bridges Healing Center will not be allowed by Medicare and no reimbursement will be paid by Medicare for these services as detailed in the Medicare contract I have signed with Between the Bridges Healing Center.

Liability & Worker's Compensation (Personal Injury: PI)
Our office will not become involved in disputes arising from personal injury or liability claims. All services will be paid at the time of service. It is your responsibility to forward them to your attorney if you wish. Financial responsibility ALWAYS rests with the patient.

I have read and understand the above Financial Policies in their entirety.
Signature of
Financially Responsible Party_____ Date_____

Between The Bridges Healing Center, LLC
RECEIPT OF NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 1, 2005

This notice of Privacy Practices describes how your medical information may be used and disclosed by *Between The Bridges Healing Center* and how you can get access to this information. Please review carefully.

Each time you visit **Between The Bridges Healing Center** a record of your visit is generated, including information about why you were seen, your treatment and billing related information. This notice applies to these types of records. **Between The Bridges Healing Center** is required by law to maintain the privacy of your records and to provide you with a description of our privacy practices. We maintain careful safeguards to protect you against unauthorized access and use. We are also required to abide by the terms of the notice currently in effect.

USES AND DISCLOSURES
The following categories describe examples of how we may use and disclose your medical information:

For treatment: Our facility will need access to your information in order to properly treat you. If at any time, your medical information needs to be shared with an outside facility, you will be required to sign a Release of Information.

For payment: Our facility may use and disclose medical information about your treatment and services to bill and collect payment from you.

For Health Care Operation: Members of our medical and management staff may use information in your health record to assess the care and outcomes in your case and other like it. The results then will be used to continually improve the quality of care for all patients we serve.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include certain laboratory tests and over reading of x-rays. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we have asked them to do. We do require our business associates to appropriately safeguard your information.

As required by law, we may also use and disclose medical information to assess your satisfaction with our services, for conducting training programs or reviewing competence of health care professionals, for research, to individuals involved in your care, to Law Enforcement or legal proceedings as required by law or in response to a valid subpoena, and to meet State Specific Requirements.

YOUR HEALTH INFORMATION RIGHTS
Although your health record is the physical property of **Between The Bridges Healing Center**, you have the right to inspect and copy medical information that may be used to make decisions about your care. If you feel that the medical information we have is incorrect or incomplete, you may ask us to amend the information.

(Continue and Sign on Reverse)

You have the right to request an amendment for as long as the information is kept. We may deny your request for amendment. If this occurs, you will be notified of the reason for the denial. You have the right to request an accounting of disclosures that are made of your medical information. You have the right to request a restriction or limitation on the medical information that we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care. **Between The Bridges Healing Center** is not required to agree to your request.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time.
To exercise any of your rights, please obtain the required forms from the office manager and submit your request in writing.

CHANGES TO THIS NOTICE
Between The Bridges Healing Center reserves the right to change this notice and the revised or changed notice will be effective for the information that we already have about you as well as any information that we will obtain in the future. The current notice will be posted in our lobby with the effective date. Each time you register for treatment, you will be offered a copy of the current notice in effect.

COMPLAINTS
If you believe you privacy rights have been violated, you may file a complaint with the office manager. You may also contact the Secretary of the Department of Health and Human Services at 1-800-368-1019. You will not be penalized for filing a complaint.

Other uses and disclosures of medical information not covered by this notice or by the laws that apply will be made only with your written permission. If you provide permission to us to use or disclose medical information about you, you may revoke this permission, in writing, at any time. If you revoke your permission, we will no loner use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If you would like to be notified of announcements, upcoming events or special offers from Between the Bridges Healing Center, please check here _____ and share your email address here _____.

_____ _____
Signature of Patient Date