

CENTER FOR INTEGRATIVE MEDICINE

PATIENT DEMOGRAPHIC FORM

(PLEASE PRINT)

Primary Provider seen in our office: _____

PATIENT INFORMATION

Legal First Name: _____ Legal Last Name: _____

Middle Name _____ Name you prefer to go by _____

Date of Birth _____ Sex: (please circle) Male Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone (_____) _____ (please circle) home cell work

Secondary Phone (_____) _____ (please circle) home cell work

SS# _____ Email Address _____

Would you like to receive a copy of our monthly newsletter via email? YES NO

Marital Status: S M D W Spouses Full Legal Name _____

Employer: _____ Employer Phone: (_____) _____

Emergency Contact (someone not living in your household)

Contact Name _____ Relationship to patient _____

Primary phone _____ Secondary phone _____

Person responsible for bill if patient is a minor: _____

Birth Date: _____ Phone: _____

Address (if different): _____

INSURANCE INFORMATION: (Please complete this section in full. Info needed may not appear on card)

PRIMARY INSURANCE

Insurance Company _____

Primary Cardholder's Information: **please check box if information is the same as above**

Name _____ SS# _____ DOB _____

Relation to Primary Cardholder _____

Secondary Insurance

Insurance Company _____

Primary Cardholder's Information: **please check box if information is the same as above**

Name _____ SSN#: _____ DOB _____

Relation to Primary Cardholder _____

I, THE UNDERSIGNED, GIVE AUTHORIZATION TO TREAT AND ASSIGN DIRECTLY TO THE CENTER FOR INTEGRATIVE MEDICINE, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE: _____ **DATE:** _____

CENTER FOR INTEGRATIVE MEDICINE

CLINICAL TESTING NOTIFICATION CONSENT

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by ***initialing*** the appropriate response:

_____ Please call me at this number _____ or _____

If I am not available at one of the numbers listed above, I authorize you to leave a message on my answering machine (and/or voice mail)

Yes

No

OR

I authorize you to leave a message with my spouse or family member

Yes

No

_____ Please mail my results to:

We will make 3 attempts to contact you. If we cannot reach you by phone, we will mail you the results at the mailing address you provided in your medical chart.

I understand that it is my responsibility to notify the Center for Integrative Medicine ***in writing*** if this information changes.

Patient Signature: _____

Witness: _____

Date: _____

Notifications and Releases

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. **Please read them carefully and sign where indicated that you have read each statement.**

****General Consent for Treatment** We look forward to treating you as a patient, however, we need your permission for our physicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I give general consent to be treated. _____ Date: _____

Patient / Patient's representative

****Financial Policy / Assignment of Benefits** As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services.

A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee. _____ (patient initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. Balances not paid within 30 days after your first treatment will be subject to a 1½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorneys' fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

_____ Date: _____
Patient / Patient's representative

****Privacy Policy** New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.

_____ Date: _____
Patient

CENTER FOR INTEGRATIVE MEDICINE
Jeffrey S. Jump. M.D.
1100 E. Third Street. Suite G-100
Chattanooga, TN 37403 Phone: (423) 643-2246
Fax: (423) 643-2030

PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

I understand the above statement and (check one box below):

- () I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.
- () I want my medical information to remain confidential. My protected health information should *NOT* be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

Patient Signature

Date

Emergency Treatment EXCEPTION: If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

Created on 03/25/03

Please describe the major health concern that you wish to address in this visit.

Health Concerns	Provider's Comments

Have you seen any other providers for this health concern? Yes No

Please list any other significant concerns that you currently have:

Please list any surgeries, hospitalizations or major illness you have had. Please note the approximate dates of these events.

Please list all medications which you currently take. Include non-prescription medications such as Tylenol.

Medication	Dose	Frequency	Prescribed By	Provider Notes

Please list all supplements, vitamins, and herbal products.

Supplement, etc.	Dose	Frequency	Prescribed By	Provider Notes

Do you have any allergies to food or medications? Yes No If yes, please list below:

Medication or Food:	Reaction:

Personal Health History

Have you been diagnosed with any of the following illnesses?

Illness	Yes	No	Year	Provider Notes
Anemia				
Asthma				
Blood clots				
High blood pressure				
High cholesterol				
Cancer				
Chronic fatigue syndrome				
Gestational Diabetes				
Diabetes				
Endometriosis				
Fibromyalgia				
Glaucoma				
Hepatitis				
Heart disease				
HIV/AIDS				
Kidney stones				
Migraine				
Thyroid disease				
Seizures				
Sleep apnea				
STD's				
Stroke				
Others:				

Personal Health History:

Have you had:	No	Yes	If yes, when? Month/Year	Provider's Comments
Blood pressure check			/	
Urinalysis			/	
Glaucoma Screening			/	
Eye exam			/	
Chest X-ray			/	
Cholesterol test			/	
Stress Test (for heart)			/	
Test of stool for blood (Stool Guaiaac Test)			/	
Colonoscopy			/	
Flexible sigmoidoscopy			/	
Rectal exam to examine prostate (males)			/	
PSA blood test for prostate (males)			/	
Mammogram (females)			/	
Pap/pelvic exam (females)			/	
Bone Density Test (females)			/	

Which immunizations have you had?

Immunizations	No	Yes	If yes, when? Month/Year	Provider's Comments
Tetanus			/	
Flu Vaccine			/	
Pneumonia vaccine			/	
Hepatitis A			/	
Hepatitis B			/	
MMR			/	
Chicken Pox			/	

Family History

Family History	If Living, Age?		If deceased, cause and age of death?	Provider's Notes
Father:				
Mother:				
Paternal grandfather				
Paternal grandmother				
Maternal grandfather				
Maternal grandmother				
Siblings:				
Have any of your relatives had the following?	No	Yes	If yes, which relative?	Age of time of diagnosis?
Heart disease (Heart attack, heart surgery, etc)				
Stroke				
High Blood Pressure				
High cholesterol				
Diabetes				
Thyroid Disease				
Breast Cancer				
Other Cancer(s)				
Depression				
Mental Health disorder				
Suicide				
Osteoporosis				
Alcoholism				
Drug Abuse				
Migraines				

Pain Assessment:

- 1. Where does it hurt? _____
- 2. How long does the pain last? _____
- 3. What makes the pain worse? _____
- 4. What makes it better? _____

5. Describe the quality of your pain (Circle all that applies.) Burning Throbbing
Spasm Piercing Sharp Dull Heavy Stabbing
Nagging Steady Intermittent Other _____

6. Using the pain scale of 1-10, with zero meaning no pain and 10 meaning worst pain, what level is your pain now?

Least pain very mild mild moderate severe worst pain
0 1 2 3 4 5 6 7 8 9 10

what level is your pain usually?

Least pain very mild mild moderate severe worst pain
0 1 2 3 4 5 6 7 8 9 10

7. When did this pain begin? _____

8. Does it vary? _____ How? _____

9. What level of pain can you tolerate with activity of daily living?

Least pain very mild mild moderate severe worst pain
0 1 2 3 4 5 6 7 8 9 10

10. Does your pain interfere with your activity?

Daily Living?

Yes No Sometimes _____

Emotions?

Yes No Sometimes _____

Family?

Yes No Sometimes _____

Work?

Yes No Sometimes _____

Sexuality?

Yes No Sometimes _____

Relaxation?

Yes No Sometimes _____

Lifestyle Habits

- Do you routinely wear a seat belt? Yes No
- Do you have any pets? Yes No
- Are you sexually active? Yes No
- Are you sexually active with men women or both?

How many sexual partners have you had in the past year? _____

Are you using a form of contraception? Yes No N/A

Have you ever had a sexually transmitted disease? Yes No

Have you ever had a blood transfusion? Yes No

Have you ever used intravenous drugs? Yes No

Exercise

Consider your physical activity during the last month and check the box next to the statement that best describes your exercise habits:

How often do you exercise

- Daily or almost daily
- 3 - 5 times a week
- 1 - 2 times a week
- A few times a month
- Less than once a month

How long do you exercise?

- Over 45 minutes per session
- 30-45 minutes per session
- 20-30 minutes per session
- 10-20 minutes per session
- Less than 10 minutes per session

What types of activities do you perform?

- Walking
- Running
- Swimming
- Housework/Yard Work
- Flexibility exercises
- Strength Training
- Sports
- Yoga
- Cycling
- Hiking
- Other

Nutrition

Please describe your typical diet:

Breakfast _____

Lunch _____

Dinner _____

Are there any foods that you avoid? _____

Do you follow any certain diet plan? If yes, please note what type. _____

How many fruits and vegetables (1/2 cup serving size) do you usually eat daily?

1-2 3-4 5-6 >7 .

How many servings of whole grains (1/2 cup serving size) do you eat daily?

1-3 4-6 7-9 >10

How many glasses of water (8 oz serving size) do you drink daily?

1-3 4-6 7-9 >10

How many servings of meat (3 oz. serving size) do you eat daily?

0 1-2 3-4 5-6 >7

How many soft drinks (12 oz. serving size) do you drink daily?

0 1-3 4-6 >7

How many servings of caffeine do you drink daily?

_____ coffee _____ soda _____ tea

How many alcoholic drinks do you drink weekly? (serving size: 12 oz beer, 5 oz wine, 1/2 oz liquor)

0 <1/mo <1/wk 1-4/wk 5-8/wk >8/wk

If you drink alcohol, please answer the following questions:

1. Have you ever felt you should cut down on your drinking? Yes No
2. Have people annoyed you by criticizing your drinking? Yes No
3. Have you ever felt bad or guilty by your drinking? Yes No
4. Have you ever had a drink first thing in the morning to get rid of a hangover? Yes No

Tobacco Use

Do you now, or have you in the past, used tobacco products? (Circle One)

Never

In past When did you quit? _____

How much did you smoke? _____

How long did you smoke? _____

Current How much do you smoke? _____

How long have you smoked? _____

Have you every tried to quit? Yes No

Number of attempts to quit? _____

What method have you used to quit? _____

Do you desire to quit? Yes No

Do you now, or have you in the past, used recreational drugs? Yes No

If yes, then what have you used? _____

How long? _____

How often? _____

Depression

Circle the statements that you easily answer "yes" to.

1. I am unable to do the things I used to do.
2. I feel hopeless about the future.
3. I can't make decisions.
4. I feel sluggish or restless.
5. I am gaining or losing weight.
6. I get tired for no reason.
7. I am sleeping too much, or too little.
8. I feel unhappy.
9. I become irritable or anxious.
10. I think about dying or killing myself.

Sleep

How many hours per night are you sleeping? _____

Do you have trouble falling asleep or waking up in the night? (Circle One)

How often? _____

Do you wake up feeling refreshed? Yes No

Do you snore or hold your breath while sleeping? Yes No

Do you have trouble staying awake while sitting quiet? Yes No

Stress Management

On a scale from 1-10, with 10 being the worse stress, what is your normal everyday stress level? Circle one.

0 1-2 3-4 5-6 7-8 9-10

Where does most of your stress come from? _____

How do you manage your stress? _____

How does stress affect you? _____

Do you have a spiritual framework? _____

What brings you the greatest joy? _____

What things in life create the greatest challenges for you? _____

What is your greatest fear? _____

What are your overall goals in terms of your health and lifestyle for the present and for the next 5 years? _____

What would success look like from this encounter? _____

Clinician Comments on History

Symptom Review: Circle the symptoms that you are experiencing.

General

Weight change
Fever Fatigue
Chills
Night sweats
Appetite change
Sleep problems

Skin

Itching
Rash
Mole change
Hair change
Color change
Non-healing sores

Eyes

Vision change
Double vision
Pain
Spots / Floaters
Itching
Watering
Redness

Ears

Ear pain
Hearing loss
Use of hearing aid
Ringing in ears

Nose

Nose bleeds
Congestion
Runny nose
Itching
Sinus problems

Mouth, Throat

Teeth problems
Mouth sores
Sore throat
Difficulty swallowing
Hoarseness

Neck

Lump
Swollen glands
Pain

Breasts

Lump
Pain
Nipple discharge

Lungs

Cough
Wheeze
Shortness of breath
Sputum
Coughing up blood

Heart/Vessels

Chest pain
Swelling feet/legs
Palpitations
Murmur
Calf pain with walking
Varicose veins
Easy bruising / bleeding

Stomach

Heartburn
Nausea / Vomiting
Diarrhea
Constipation
Bowel changes
Bloody stools
Black stools
Abdominal pain
Excessive gas/belching
Hemorrhoids

Urinary

Burning
Frequent urination
Painful urination
Blood in urine
Reduced urine flow
Hesitancy
Dribbling
Wake up to urinate
Incontinence

Muscle/Skeleton

see pain assessment
Joint pain
Joint swelling
Joint redness
Neck pain
Back pain
Muscle pain

Neurological

Paralysis
Seizures
Fainting
Muscle weakness
Balance problems
Coordination problems
Numbness
Tremors
Memory changes
Headache

Female Reproductive

Abnormal vaginal bleeding
Vaginal discharge
Vaginal dryness
Vaginal itching
Painful intercourse
Painful periods
PMS
Hot flashes / Night sweats
Problems with sex
Genital sores
(G: __ P: __ AB: __ SAB: __
LC: __)

Male Reproductive

Discharge from penis
Sores on penis
Testicular pain
Testicular lump
Problems with sex
Erection problems
Prostate problems

Emotional

Depression
Loss of sleep
Nervousness
Anxiety
Stress
Trouble concentrating